MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
20 January 2015 (7.00 - 10.00 pm)

Present:

Councillors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Patricia Rumble, Jason Frost and Darren Wise

Apologies for absence were received from Councillor Gillian Ford (Councillor Darren Wise substituting).

Officers present:
Matthew Hopkins, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Rachel Royal, BHRUT
Victoria Wallen, BHRUT
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Steve Walters, Consultant, NHS Property
Ilse Mogensen, Commissioning Support Unit

22 **ANNOUNCEMENTS**

The Chairman gave details of action to be taken in case of a fire or other event that may require the building's evacuation.

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

Apologies were received from Councillor Gillian Ford with Councillor Darren Wise substituting.

24 **DECLARATIONS OF INTEREST**

There were no declarations of pecuniary interest.

25 **MINUTES**

Under minute 28, it was clarified that there were in fact forty-eight GP practices in Havering rather than fifty-eight as stated.

Other than this correction, the minutes of the meeting held on 6 November 2014 were agreed as a correct record and signed by the Chairman.

26 BHRUT PALS SERVICE

BHRUT officers explained that there were Patient Advice and Liaison Service (PALS) offices at Queen's and King George Hospitals open 10 – 12 pm and 2 pm – 4 pm. There were also a number of PALS phone lines open 9 am to 5 pm daily. The PALS team comprised three full-time and one part-time officer with the support of several volunteers.

The main areas PALS dealt with included general advice & signposting to relatives, analysing and responding to patient comment cards and logging and responding to compliments about services. Translation and interpretation services were for the Trust were also managed by PALS.

A total of 6,432 cases had been logged by the service in 2014 of which 5,720 were concerns. The most common area of concern related to appointments with other main categories being admission issues and problems relating to treatment received.

PALS aimed to resolve concerns directly with services but it could be difficult to provide timely feedback to enquiries. Signposting to formal complaints processes could also be carried out of necessary. There were no set national or local timeframes for PALS responses.

The capacity of the PALS service was also a problem. The service standard of a response within 48 hours was now being audited. One option was to reduce the number of PALS phone lines in order to allow staff more time to respond to existing issues.

Eight-five per cent of cases referred were successfully resolved by PALS. PALS staff were now attending more support groups for e.g. diabetes sufferers and PALS awareness days had been held at both hospital sites in order to publicise the service. Next steps for the service would see a standard operating procedure drafted which would see escalation of unresolved issues to a general manager after five days and to a clinical director after 10 days.

Another option being considered was to have a member of PALS staff working in the appointments call centre in order that queries relating to appointments could be dealt with more quickly. PALS officers could also be present in for example A & E or the children's ward.

Officers accepted that calls to PALS needed to be answered in a more timely manner. Around 60% of reports to PALS related to Queen's Hospital and 40% to King George.

Many of the appointments team at the Trust were quite junior and training was in progress with this team in order that they would go back to the consultant or service more with any queries that had arisen. The Trust Chief Executive added that the point of contact in the relevant service should

resolve appointment concerns direct. He also wished to introduce alteration of appointments being undertaken on-line. There was a need to change the Trust's culture to fix concerns at the point of contact. There was also a need to train consultants in the computer system in order that they could book appointments direct.

Some 93% of PALS calls were now answered which compared to 40-45% previously. At peak times such as Monday mornings however, the call answering rate was lower.

Of those issues not resolved by PALS, some related to other organisations while other matters were referred to the formal complaints process. The wording on the automated response to PALS e-mails had recently been changed to state there would be a contact within 48 hours rather than the issue being resolved within this time. The suggestion that PALS staff wear different coloured uniforms in order to be more recognisable was welcomed and would be considered. Lanyards and name badges were now worn by all staff.

It was emphasised that treatment would not be affected if people complained and research had shown that not many patients were in fact concerned about this.

27 **PATIENT FLOWS**

The BHRUT Chief Executive explained the period October – December 2014 had been very challenging in terms of patient flows. The benefits of the Trust's new initiatives in this area were however now starting to be seen. The Trust's winter resilience procedures had been planned for several months and had been drawn up with the Council, CCG, NELFT and the London Ambulance Service.

Flu jabs had been provided to reduce the impact on both staff and public. There were now approximately 45% of front line staff who had received the vaccination although the Trust's target was 75%.

A Majors Lite unit had been introduced into A&E to speed up dealing with patients who may not need admittance onto a ward. These patients were seen in a separate area. An increasing proportion of discharges (around 30%) now took place in the morning. The majority still occurred after 12 pm however.

The number of patient admissions to BHRUT was very consistent at 95-100 per day. Daily discharge numbers were however more variable. A bed manager was now based in A & E and a bed manager was also present in the assessment units. It was important that the pace of work in A & E was matched in the rest of the hospital.

The Chief Executive emphasised that clinicians had not been told to discharge patients too quickly and had to give a good clinical case for doing so. Admissions and discharges should be decided by consultants rather than junior doctors and this was the position the Trust was aiming for across its wards.

It was confirmed that it was monitored which nursing homes sent patients to A & E most often. A pilot scheme was in progress whereby a senior geriatrician was based in A & E in order that decisions could be reached more quickly on whether patients from care homes needed admission into the hospital. It was also noted that most Havering care homes now had a GP aligned to them. By the GP visiting the home on a weekly basis, the number of residents needing to go at A & E could be reduced.

The Trust Chief Executive agreed that it was unacceptable for triage to be carried out in clear sight of people queuing at A & E reception and the environment was not conducive to confidentiality. The issue of privacy would be addressed in the forthcoming reconfiguration of the A & E department.

The JONAH system was still used in discharge work as this was a consistent predictor tool for discharge. The Trust as a whole needed to discharge 100 patients daily, seven days per week. The elders receiving unit had consultant presence seven days per week but there remained vacancies to fill before this could be achieved on the Medical Receiving Unit. The Trust has been pleased with the response of the medical teams during the peak winter period.

It was noted that the Joint Assessment and Discharge Team had been put together by the health economy and that this helped discharge by for example compiling care packages more quickly. People waiting in the hospital discharge lounge were likely to be less complex discharge cases.

The Chief Executive accepted that there were still issues with people receiving their medication promptly on discharge. Early writing up and dispensing of prescriptions was needed and pharmacists were present in the Elders Receiving Unit in order to facilitate this. Medication could be delivered to patients after discharge but this depended on the complexity of the case. It was also agreed that it was not acceptable for a residential home not to be advised of a patient's discharge from hospital. Communication between the hospitals and homes needed to be improved.

The Trust was legally required to treat people who may be very intoxicated and it was noted that mental health issues could also be present in such patients. It was suggested that the Council could assist with public health issues such as alcohol abuse but this was a national problem. Temporary units were deployed in Romford town centre for example at New Year. The Trust Chief Executive indicated he was happy to be involved in work on drafting the Council's new licensing strategy.

The Trust was due to receive a new inspection from the care Quality Commission starting on 2 March. It was noted that the Trust's Chief Nurse was leaving and that a replacement was being recruited. As regards recruitment and retention at the Trust as a whole, 85-90% of nursing posts in A & E were filled. Poor performing staff were moved on and it was accepted that there remained vacancies for e.g. intensive care nurses and A & E doctors. These were however also national issues. A recent recruitment day for Health Care Assistants had generated a lot of interest. Details would be supplied to the Committee of the Trust's next recruitment day.

It was confirmed that the Trust ran a Return to Practice scheme where nurses who wished to return to the profession could receive appropriate training.

The Committee **NOTED** the update and thanked the Chief Executive and colleagues for attending.

28 ST GEORGE'S HOSPITAL

The Chief Operating Officer of Havering Clinical Commissioning Group (CCG) explained that the CCG wished to have a health and wellbeing centre on the site of the former St George's Hospital. An outline business case for the proposal needed to be submitted by the end of March.

A workshop had been held to update the plans for the facilities to go on the site which included a number of potential areas. There may not be a full GP practice on the site but access to GPs (as well as nurses and opticians) was likely to be offered. This could be for registered or non-registered patients. Working patients would be able to see a 'drop-in' GP at the site.

It was emphasised that the CCG wished to have services on the site that people wished to use and that were viable for the medium term (5-10 years). Members were not involved on the St George's steering group but had been invited to the recent workshop. The CCG was keen to engage with the Sub-Committee on the St George's issue and would look at involving Member as well as the Council's Group Director in relevant meetings.

Patients treated at St George's would be mainly from Havering but could come from other areas depending on what services were available at the site. Other proposed facilities included space to be used by the voluntary & community sector, or by Council services, an education and training centre for local people and NHS staff, diagnostics such as potentially x-ray or phlebotomy and a short-stay, rapid access assessment and diagnostic unit. A rehabilitation therapy centre was considered but this had now been overtaken by the introduction of new rehabilitation services.

Services such as diagnostics and the day assessment unit needed further work to ensure that they would be fully used if they were to be introduced to the site.

The findings of the recent workshop had included that services should be co-located and that the site should have a focus on wellbeing. It was felt that some mental health services should be available on the site and that the sharing of care records within a multi-disciplinary approach would be the best way to address patients' needs.

Specification and modelling for the facility was being developed prior to the submission of the outline business case. There had also been significant changes to the local health economy recently with the GP Federation being established and evening and weekend GP access being introduced. The complex care organisation – Health 1,000 was also now in operation.

An options appraisal of the proposed new services at St George's was currently underway. Funding for the new facilities would be separate from the rest of the health economy. Funds from the sale of the St George's site went into national resources and the CCG could apply for capital to build the new centre at St George's. It was also confirmed that NHS 111 would direct patients to any services on the St George's site.

There was not likely to be a walk-in centre at St George's as the CCG wished to build up the capacity of the existing GP hubs. The GP Federation hubs or NHS 111 would be able to supply GP appointments in the future and the CCG wished to reduce the demand for GP appointments. The Chief Operating Officer of the CCG agreed to check the number of patients at Harold Wood clinic who arrived with urgent needs and needed to see a GP.

It was confirmed that the short stay facility would be a day unit with no overnight beds. A primary care community team on the site could see patients on site or in people's homes. This could include day clinics and outpatient appointments. The facility overall would be a combination of office base and treatment centre.

A representative from NHS Property then explained that the overall St George's site comprised 11.74 hectares of Green Belt and that the hospital had been decommissioned in 2012. A lot of work had been undertaken on the proposals with Council planning officers. The plans for housing had been presented to Cabinet, local ward Councillors and the Regulatory Services Committee. A public exhibition of the housing plans in December 2014 had been attended by over 100 people and received 40 written responses. About 80% of responses received had been positive. Concerns raised had covered areas such as healthcare facilities, traffic impact and the effect on the local infrastructure.

The St George's site being Green Belt land meant redevelopment could only take place to the overall area of the existing buildings. There were also

nature conservation issues on the Ingreborune Valley side of the site. The existing buildings were in poor condition but did have heritage value. A new access point would be needed and it was noted that the land to the east of the site was owned by a third party which would mean further access issues.

Healthcare would occupy 15% of the site and it was planned to locate these facilities on the north west corner of the site, nearest to the station and town centre. The road along the frontage of the hospital would receive a new junction for access and would be widened to assist the flow of traffic.

Ancillary buildings such as the laundry, corridor and large chimney would be demolished but some buildings such as the Gate House, Ingrebourne and administration buildings would be retained. Retained buildings could be converted into apartments.

The healthcare facility would be up to 3,000 m2 of floor space with 50 parking spaces. There would be a total of 130 apartments and 160 houses built on the site. The work had been split into nine indicative phases although the developer would make the final decisions on this. It was confirmed that the healthcare and residential elements would be covered by separate planning applications which would be submitted in the next few weeks.

15-20% of the properties would be affordable housing. It was anticipated that a developer would be appointed by late 2015 and work, on the residential areas, would start by late 2016. Most of the housing would be 2-3 stories although three apartment blocks would be up to 4 stories in height. These would however be difficult to see from Suttons Lane. The housing would be built to wheelchair adaptable standards.

The Chairman added that ward Councillors who had attended the public consultation had been pleased with the presentation and that 97% of local residents were in favour of the housing plans.

The Sub-Committee **NOTED** the update and thanked officers for their input into the meeting.

29 HEALTHWATCH HAVERING - ENTER AND VIEW VISITS

A Director of Healthwatch Havering explained that Enter and View visits were an important part of the organisation's work and formed part of the statutory powers of Healthwatch. Health and social care premises were visited by Healthwatch from the point of view of the service user. Healthwatch considered what patients and residents thought. Reports of

visits were placed on the Healthwatch website and also sent to the Care Quality Commission, the Council and the CCG.

Healthwatch sought to make recommendations that made life easier for residents or patients such as e.g. the installation of a new sink and taps. Healthwatch always sought to make constructive criticism in its reports. It was possible to refuse admission for a visit but Healthwatch would report if this had happened.

Enter and View visits could be announced or unannounced. Healthwatch usually gave a time period within which they would be carrying out a visit not the exact date of when the visit would take place. Unannounced visits were also undertaken.

Healthwatch liaised with the Care Quality Commission and the Council's Quality Assurance team. Healthwatch volunteers were trained in Enter and View, safeguarding and deprivation of liberty issues. Most Healthwatch Havering volunteers were retired health or social care professionals and were hence well informed. Healthwatch Havering strived to be a critical friend to organisations it scrutinised.

Enter and View visits had been carried out at care homes for older people and for people with learning disabilities. The Healthwatch website showed reports and recommendations made relating to each visit and also gave a link to further details of each care home. An Enter and View visit had also been undertaken to the Queen's Hospital maternity unit. A visit had also recently been undertaken to a ward at Goodmayes Hospital.

The Enter and View powers covered hospitals, GPs, dentists, pharmacies and opticians. A lot of different GPs had been found by Healthwatch to be seeing patients in care homes leading to more visits to A & E and work had been undertaken with the CQC to reduce the number of different GPs involved at each care home. Enter and View powers allowed the identification and resolution of these types of problems.

The choice of location for Enter and View visits was discussed with the Care Quality Commission and Quality Assurance Team. Some 'good' rated homes had also been visited.

30 URGENT BUSINESS

There was no urgent business raised.

Chairman

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