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HEALTH & WELLBEING BOARD

AGENDA

Wednesday 13 November 2013

1.30 pm – 3.30 pm

Committee Room 1, Town Hall

1. CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. APOLOGIES FOR ABSENCE

(If any) – receive

3. DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting. Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. MINUTES (Pages 1 - 10)

To approve as a correct record the minutes of the meeting held on 9 October 2013 and to authorise the Chairman to sign them.

5. MATTERS ARISING/REVIEW OF ACTION LOG (Pages 11 - 12)

6. FRAIL ELDERLY AND THE INTEGRATED CARE STRATEGY (Pages 13 - 18)

Presentation from Jacqui Van Rossum - Executive Director Integrated Care London & Integration and Dr Steve Feast - Executive Medical Director.

7. INTEGRATION WITH HEALTH

a) Joint Report from Adult Social Care and Havering CCG on section 256 monies.

Report by Alan Steward & Paul Grubic *To follow*

b) Future work on Integrated Transformation Fund

Report by Joy Hollister & Alan Steward *To follow*

8. CANCER AND CARDIOVASCULAR PROGRAMME (Pages 19 - 30)

Details of a consultation on cancer services across London.

Presentation by Kathy Pritchard, Chief Medical Officer, London Cancer, Neil Kennett-Brown, Programme Director, NHS England

9. ANY OTHER BUSINESS

10. DATE OF NEXT MEETING

Members of the Board are asked to note the date of the next meeting is on Wednesday 11 December 2013 at 1.30 pm.

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Commitee Room 2 - Town Hall
9 October 2013 (1.30 pm – 3.45 pm)

Present

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
John Atherton, NHS England
Conor Burke, Accountable Officer, Havering CCG
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH
Anne-Marie Dean, Chair, Health Watch
Joy Hollister, Group Director, Social Care and Learning, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Dr Gurdev Saini, Board Member, Havering CCG

In Attendance

Averil Dongworth - Chief Executive Officer – Queens Hospital Trust
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Observers from Public Health

Apologies

Cheryl Coppell, Chief Executive, LBH
Dr Mary E Black, Director of Public Health, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH
Alan Steward, Chief Operating Officer (non- voting) Havering CCG

51 **APOLOGIES FOR ABSENCE & SUBSTITUTE MEMBERS**

Apologies were received and noted.

The Chairman requested that named substitute/s should not attend Board meetings in place of a principal member/s. Items on the agenda due to be presented by members should not be introduced by non-members.

52 **DISCLOSURE OF PECUNIARY INTERESTS**

None disclosed.

53 **MINUTES**

The Board considered and agreed the minutes of the meeting held on 11 September 2013 which were signed by the Chairman.

54 MATTERS ARISING/REVIEW OF ACTION LOG

Following the presentation on Dementia received at the last Board meeting, it was agreed that the post of Dementia Programme Manager would be extended beyond the current six month tenure. Representatives of the Local Authority and the Clinical Commissioning Group confirmed that this would be funded by the Integrated Care budget and that the matter would be progressed.

Work on the formation of the Joint Assessment & Discharge Team was in progress and it was anticipated that the team would be in place by April 2014.

It was noted that 7 Day Working would be introduced by BHRUT at the hospital as of November 1 2013 together with the GP Weekend Scheme also scheduled to commence in November. Two GP surgeries are required to participate - one surgery would be within close proximity to Queens Hospital and one further away; expressions of interest are currently being sought from GP surgeries. The Board agreed that these measures were timely in relation to the onset of winter pressures. The Chairman offered the use of the Local Authority magazine and the website to publish the weekend service to ensure that patients are informed and aware of the services. NHS England stated that they had requested that all Public Health improvements should be advertised.

The Chairman had written to the local newspaper in response to an article on the future of the St George's Hospital site.

The Board welcomed Margaret McGlynn, Care Quality Commission Compliance Manager to provide a briefing on the CQC revised inspection procedures for hospitals. The Board noted the following:

- The CQC were changing the way they worked and had adopted new inspection processes. Future inspection reports would look different in that they would be talking about services and the leadership within those services. Inspection will be based upon 5 domains – safety, effectiveness, responsiveness, caring and well-led
- The inspection teams had increased in numbers (up to 36 members) and would include independent experts (e.g.; clinical consultants, directors of nursing, hospital chief executives and experts by experience).
- Areas to be inspected included: A&E, maternity, paediatrics, acute medical and surgical pathways, care for the frail elderly, end of life care and outpatients.
- Inspection teams would be on site between 5 – 7 days. Each service would be reported on and this would form part of an overall executive summary.

In order to test the modifying process and obtain useful feedback, the final report would be subject to a Question and Answer session prior to

publishing. A new rating system had also been introduced and would be applied following the inspection. This would not be based on stars/symbols but by a narrative driven by the 5 domains.

Members of the Board requested to know how the CQC evaluated interactions between staff and patients on assessing care, and whether they would be investigating cancelled appointments. The Board were advised that these areas would come under responsiveness and that the inspectors would look at how services are working for both the public and the Trust. The inspectors would also consult with the public as to what they think the priorities should be and likewise with the Trust.

It was noted that a recent inspection of King George's Hospital carried out in August had been very positive. A further inspection of Queens Hospital would commence on Monday 14 October 2013.

Members of the Board enquired whether the CQC would be seeking the views of GPs as well as patients. The Board were advised that the CQC would utilise the Health and Wellbeing Board as a forum to engage further with Local Authorities and Clinical Commissioning Groups.

The Chairman, on behalf of the Board, thanked Margaret McGlynn for attending the meeting. It was agreed that the CQC attend a future meeting to provide further updates.

55 **BHRUT UPDATE**

The Chairman welcomed Averil Dongworth, Chief Executive Officer of the Queens Hospital Trust. The Board noted the following updates:

Urgent Care Centre

The Urgent Care Centre utilisation rates were up to 32% and the CCGs were being provided with weekly reports. At the HWB Board meeting of 14 August 2013, there was a discussion about the contracted level of 45%-50%. These figures were based on a clinical audit that would agree a trajectory to increase utilisation. The audit was currently with the CCG. Original utilisation rates were very low and it had been a slow process to increase the figure to 32%. The figure had been benchmarked with other outer London Trusts where it was found to be below the average figure of 33-34%.

Members of the Board expressed their concern in that they considered 32% a low take up in usage of the Urgent Care Centre and asked what measures were being put in place to increase the figure.

The Chief Executive of BHRUT advised that it was essential to put the right patients with the right treatment in the right place. A lot of work was done to stream patients or redirect them to GPs on arrival in A&E. The Trust would like to achieve a utilisation figure of 40 % and work was on-going in

developing the NHS England UCC model and using it as a template. It was also the view of the Chief Executive of BHRUT that the CCG ought to pay the right tariffs for work done and that a clinical audit would help in addressing this issue. The CCG were billed for patient's treatments, however if temporary staff were not recording treatments appropriately, then information could not be correctly coded which in turn affected the figures. It was therefore very important to have permanent staff and a modern IT system.

A member representing the CCG advised that the CCGs had not been very proactive in the past but would be leading now as they had a better understanding of the position. A&E admissions had decreased slightly whilst attendances had increased marginally and there was still a lot of work to do. UCC utilisation rates were only 23% 2 years ago and the CCG would be investigating how the service is commissioned.

It was noted that Queens A&E was being redeveloped. There would be separate doors to A&E and the UCC which would make it easier to staff.

It was confirmed that both UCCs at Harold Wood and Queens Hospital were operated by the same provider. The Chairman questioned why the Harold Wood centre was not being run according to the original plan of closing at 8.00pm and closed its doors to new patients at 6.00 pm. The centre should support 6 GPs and provide a 24 hour service. The representative from NHS England said that he would raise this issue in a meeting with primary care colleagues. The Chairman offered to forward the original plans if required.

The Chief Executive of BHRUT affirmed that when ambulances ceased to arrive at King Georges, it was anticipated that 65/70% would still attend the Urgent Care Centre. From thereon ambulances would travel to either Whipps Cross or Queens Hospitals.

Queens/King George's A&E

The Chief Executive confirmed that there were plans to close the A&E at King George's Hospital to blue light admissions from ambulances around late summer in 2015. A lot of work would be carried out before then at Queens. Queens Hospital was a PFI hospital and it was important to get everything right. There were deadlines to meet and issues around clinical modelling. The Trust was working with PFI partners and clinicians had approved the plans.

Following the Clinical Review, the recommendation was that King George's A&E would not close until it was safe to do so and that the redevelopment of Queens A&E was complete. The Clinical Review had also made a number of recommendations and that these were now work in progress.

The Chair expressed a view that there had been no discussion with the Local Authority nor had there been a meeting with the Council Cabinet to discuss health matters, particularly the plans regarding A&E closure to

ambulances. The Chief Executive gave her apologies and stated that the Health and Wellbeing Board was new and that she was prepared to hold discussions with anyone at any time. A member representing the CCG stated that in the past PCTs had not been very good in communicating. The Chief Executive concurred with this view stating that the NHS itself had not excelled in this area and that in going forward, there should be more engagement with groups including Healthwatch so that all parties were clear on strategy.

The Board noted that there needed to be some clarity about the definition of an Urgent Care Centre. The Chairman of Healthwatch pointed out that patients often have a problem with what things are called by the health system. This needed to be clarified for patients to help them navigate the health system better and should be communicated nationally and locally.

Joint Projects UCB/ICB

(i) Recruitment

The Trust had formed an agreement with the Local Education Training Board (LETB, or Deanery) for 10 Clinical Fellows for introduction to Clinical Fellows/Leadership Management programmes. Efforts were also being made to repeat the same in nursing. There were joint appointments with Barts Health via the Trauma Centre and that there would be a new cohort of emergency doctors. UCB had been helpful in the task of promoting Romford as a place to live and work. Representatives from the Trust would also be travelling to India to recruit more staff. The Trust had to compete with inner London Trusts providing Acute Trauma as well as overcoming the reputation of the hospital.

(ii) Seven Day Working

7 Day Working had now been implemented in Queen's Hospital since the beginning of September, but was still not really delivering yet. The Trust had been looking at blockages in the system, however, it was confirmed that 7 Day Working was delivering a better quality of care to patients. Patients were able to see a Doctor on the ward on a Friday or Saturday which produced better outcomes. It has also been found to produce a surge of patient discharges on a Tuesday. The Trust would continue to monitor this closely as a pattern had not developed yet.

(iii) Joint Discharge

The Chief Executive of BHRUT noted and thanked the Director of Adult Social Services for her personal involvement in addressing a recent discharge problem.

(iv) Frail Elderly

A programme had begun of trialling extended opening hours over the weekends by primary care providers so as to increase the number of appointments in the system. Research was also being undertaken in conjunction with UCL on looking at data for around 500 patients audited last month to see how improvements to services can be made and the processes simplified.

The Chairman on behalf of the Board thanked the Chief Executive of BHRUT and extended an invitation to report to the HWB Board on a regular basis. The Health and Social Care Sectors were undergoing change and that health partners needed to understand how Cabinet and Scrutiny worked. It was therefore agreed that the Chief Executive would attend the HWB Board meeting to present a progress update in two months.

56 **HEALTH AND WELLBEING STRATEGY PROGRESS UPDATE - TO FOLLOW**

Priority 5: Better integrated care for the "frail elderly" population

It was agreed to defer this item to a later meeting.

57 **REFRESHING THE HAVERING HEALTH AND WELLBEING STRATEGY AND HAVERING CCG COMMISSIONING STRATEGY**

It was noted by the Board that CCG and LBH officers were in the process of reconfirming priorities and that discussions would follow receipt of the JSNA. It was anticipated that a strategy would be available by November 2013.

58 **JSNA UPDATE**

It was agreed to defer this item to a later meeting.

59 **QUARTERLY UPDATE ON SAFEGUARDING CHILDREN/ADULTS**

Children

The Board received the Havering Local Safeguarding Children Board's Annual Report 2012-2013 together with a further report highlighting aspects of the LSCB Annual Report.

Havering Multi Agency Safeguarding Hub (MASH)

A review had recently been carried out to benchmark the Havering Multi Agency Safeguarding Hub (MASH) operation with others and that a report would be released in November 2013. MASH continued to receive a high

level of referrals of which a number were attributable to police MERLIN[1] notifications made to Children's Services when a child comes to the notice of the police. This was being addressed by the police who were looking into how they screen their work and reduce unnecessary information sharing with different agencies.

Child Protection Processes

The Havering Local Safeguarding Children Board (LSCB) Quality and Effectiveness working group continued to scrutinise the whole area of child protection. Thus far, the quality of the work has been good however Children's Social Care have identified cases that remain on a child protection plan for only three months whilst others remain on a plan for 2 years. An audit will be carried out and findings reported to the Quality and Effectiveness working group.

Looked After Children

Looked After Children had not been performing well however significant progress had been made following the implementation of an improvement plan. It was noted that there had been no serious case reviews during the last financial year. A priority for the partner agencies was to secure long term stability for Havering's most vulnerable children with permanent and adoptive placements.

Early Help

The LSCB agreed an approach to Early Help in July 2013. A report by the LSCB Quality and Effectiveness Group will be passed to the LSCB in January 2014 on whether the early offer of help strategy has resulted in improved measurable outcomes.

Havering LSCB

A LSCB Development Day is being planned for the LSCB Quality and Effectiveness group to explore how each partner agency quality assures its work and the methodology of reporting this information back to the Group.

Havering LSCB had a new independent chair, Brian Boxall, who would be chairing both the Children and Adults Safeguarding Boards. Havering LSCB has a responsibility to ensure that thresholds are set appropriately and fully understood. The current threshold document was developed by Children

[1] MERLIN is a Metropolitan Police database which was developed from their missing persons database. It now records details of any child who 'comes to notice' for any reason, ranging from child protection to bullying; being 'present when premises are searched'; where it is suspected that a family member has mental health problems or in any circumstances where a police officer thinks that the family needs social services involvement.

Social Care and ratified by Havering LSCB with inspection finding that practitioners understood thresholds and were confident in its application.

In response to Working Together 2013, the London Safeguarding Board is developing a threshold document in consultation with all London Boroughs with the expectation that the threshold document will be adopted by Havering LSCB in early 2014. Havering LSCB is in the process of undertaking an audit of section 11 compliance across LSCB partners. The LSCB will receive a report on agency compliance in January 2014

The Board noted the report.

Adults

The Board received a tabled report on the Safeguarding of Adults and noted the following:

The introduction of the Care and Support Bill will place Adult Safeguarding Boards on a statutory footing. The LSCB are aware of the changes that need to take place by 2014. An independent Chair has been appointed and the Board have a clear understanding of the current objectives and will be working with partner organisations to achieve common solutions.

Current Actions and Updates

- The Board has welcomed the arrival of its new independent Chair
- Winterbourne - The Board has been assured with current plans in place.
- Francis Report - CCG Board representatives will lead on Francis and will commit to reporting to the Board
- BHRUT - A further CQC inspection visit is scheduled in October and the outcome of this inspection will be reported.
- PCT/CCG – This transition has seen a change in representation and the Board have been assured of governance, frameworks and safeguarding policies in place so far.
- Self-Assessment – provider Self-Assessment report shows the CCG and health providers are effective in processes overall to safeguard adults. All Board partners will be expected to complete a Self-Assessment for their organisation.
- MERLINS – Concerns were raised relating to the volume, format, content and delay of the MERLIN referrals and the possibility of volume overwhelming MASH.

Serious Case Reviews

Inappropriate Discharges – The Board have been made aware of 3 LD cases of inappropriate discharges and have requested a more detailed report for the next Board meeting.
Board Future Actions – The Board's structure will be revised to include an additional subgroup to enable serious cases to be reviewed and highlighted for Board action.

Board Development

Outcomes of the Development Day – The outcome highlighted that the Board have not been working strategically and it was evident that immediate actions were required to ensure the SAG is fully enabled and aware to carry out its responsibilities within Havering, ready for statutory status.

Phase 1 Actions – On target to achieve.

60 **ANY OTHER BUSINESS**

None.

61 **DATE OF NEXT MEETING**

Members of the Board were asked to note that the next meeting would be held on 12 November 2013 at 1.30 pm.

Chairman

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Health & Wellbeing Board

Action Log

Minute Ref	HWB Meeting Date	Agenda Item	Actions	Estimated Completion by	HWB Lead / Actioning Officer	on future agenda?	Date Complete
5b (i)	Dec-13	Teenage Pregnancy	Teenage Pregnancy Research/Sexual Health Report	TBA	Chairman & Dr M Black	Feb-14	
5b (iii)	Mar-13	Havering Cancer Urology Services	Chair of Havering CCG to write to Chief Executive of NHS England to request public consultation in retaining Cancer Urology Services within the locality	Jul-13	Chairman & Dr M Black	Oct-13	
5b (v)	Apr-13	Integrated Care Strategy	ICM Review to undertaken in October 13 and outcome to be reported to HWB. Total Place Cost Modelling to be undertaken for one theme under ICS	Nov-13	A Steward & J Hollister	Nov-13	
7	Jul-13	Joint Strategic Needs Assessment	JSNA Stakeholder Workshop to be convened Members to advise further suggestions for themed chapters to Chairman	Oct-13	Dr M Black	Oct-13	
9	Sep-13	Children & Families Bill	Children's Services to provide further update	Deferred to a later meeting	J Hollister	TBA	
55	Oct-13	Review of Queens Hospital	Invite Chair and/or CEO to address Committee on progress and answer questions	Jan-14	Chairman & Dr M Black	Jan-14	
34		Operations/Working Group	Chairman and Director of Public Health to discuss formation of Operations/Working Group linked to Health and Wellbeing Board	Nov-13	Chairman & Dr M Black	TBA	
54	Oct-13	CQC	CQC to provide update to HWB Board	Feb-14	Chairman & Dr M Black	TBA	

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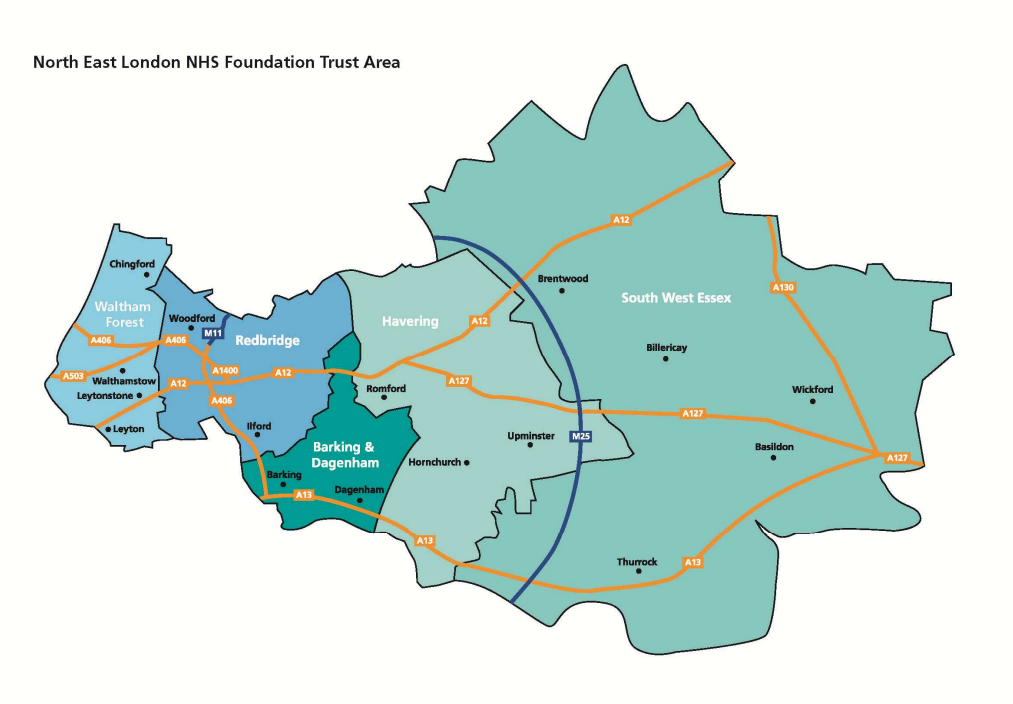
North East London NHS Foundation Trust

Briefing for Havering Health and Wellbeing Board
13 November 2013

Healthcare services in London and Essex

North East London NHS Foundation Trust (NELFT) provides mental health and community health services for people living in the London boroughs of Waltham Forest, Redbridge, Barking and Dagenham and Havering, and community health services for people in south west Essex. With an annual budget of £314 million in 2012/13 we provide care and treatment for a population of almost 1.5 million from around 145 sites.

The trust has seen many changes. Originally a mental health trust, the opportunity for NELFT to manage a much wider range of services came about through the national Transforming Community Services programme, which separated provider services from the commissioning role of the primary care trusts before introduction of clinical commissioning groups in 2013.



When Barking and Dagenham Community Health Services joined NELFT in July 2009 it was the first transfer of its kind in the country. Thanks to the dedication of staff, services quickly gained a reputation for being high quality and accessible. This paved the way for the transfer of community services from south west Essex and outer north east London including Havering in 2011.

The close link between physical and mental wellbeing is well recognised, and there are real potential benefits to the health and wellbeing of our patients and service users through the trust providing both mental health and community services. NELFT is now one of the largest providers of mental health and community services in England, with around 5,500 staff.

Community health services in Havering

Overall our community services have received a 9.2 out of 10 rating for the friends and family test. Our patient safety thermometer demonstrates a high performance of our services in delivery of harm free care with a score of 98.74%

Recent developments that have contributed to these outcomes are outlined below.

Community treatment team

- A crisis intervention for patients in the community or as an alternative pathway on attendance at A&E – Queens
- Service fully launched in April 2013 to Havering patients
- Multidisciplinary team consisting of medical, nursing, therapy and support staff
- To date the service has received 1,370 referrals for Havering patients this exceeds the planned demand for the service
- Communication plan in place to raise awareness of service with GP's, residential and nursing homes, social care and the voluntary sector
- Service operates 7 days per week 8am to 8pm

Community bed improvements

- Service improvement plan in place since April 2013
- Proactive discharge planning working with patient and family/carers
- More information being provided to patients and family/carers
- Introduction of the Butterfly scheme to support patients with dementia
- Improved liaison with social care
- Proactive system in place to deal with any peaks in demand

Integrated case management

- Proactive management of patients who are at highest risk of needing a hospital admission – MDT approach with primary and social care partners
- Reconfiguration of integrated case management (ICM) from April 2013
- ICM services aligned to groups of GP practices
- Increased activity for the teams with 900 patients being seen for first 6 months of the year
- Each patient has a full care plan and crisis plan in place

Children's service pathway development

- Integration of community health services and child and adolescent mental health services (CAMHS) in progress
- Development of a Child Development Centre in Havering
- Working with local authorities to develop with healthy child programme for the 5-19 following transfer of commissioning responsibilities
- Recruitment under the call to action campaign for health visiting services
- Development of the autism pathway

Continence service redesign – adults and paediatrics

- New service specification agreed with commissioners
- Improved access for patients with continence needs
- Dedicated children's and adult pathways
- Access via Choose and Book

Mental health services in Havering

We provide a full range of mental health services for Havering residents.

Dementia care

- Zero acute admissions for two years in Havering
- Older people's outreach teams piloting Skype and other remote assessment technology
- Establishment of a national memory clinic accreditation services
- Pioneers of cognitive stimulation therapy

Acute inpatient care

- Mascalls Park has been closed and mental health beds for Havering residents re-provided in a new state of art facility at Sunflowers Court in Goodmayes.
- Reduced the number of admissions and bed numbers via the development of home treatment and by investing in community services

Home treatment

- Recently developed a new older adult home treatment team

Admission avoidance

- Introduced a new collaborative care team at queens to facilitate early discharge and admission avoidance

Borough focus

- Redesigned mental health care pathway to a create single borough access point for mental health services

Community recovery teams

- Refocused community mental health teams to create community recovery teams which focus on providing services for those on CPA

Crisis line

- Established a new 24/7 crisis line, mental health direct.

Preparation for mental health tariff

- Undertaking work with clinicians preparing for mental health tariff by clustering our patients and creating appropriate care pathways

Nelft representatives at meeting

Dr Steve Feast, executive medical director

Dr Feast joined the trust having previously held the position of deputy CEO and director of transformation in the NHS Bedfordshire and Luton PCT Cluster. Prior to this he worked in Cabinet Office on issues relating to primary care and social exclusion, setting the Inclusion Health agenda.

For four years, Steve worked as a senior advisor in health and wellbeing at the Department of Health (DH) advising on projects relating to health inequalities, commissioning and incentives.

Before the DH, Steve was clinical innovation director of the NHS Modernisation Agency. He has worked as the National Lead PEC Chair at the National Primary and Care Trust development team and as the PCT advisor to the CHI Star Ratings team. As PCT lead in the Healthcare Commission transition team, Steve supported the design of the new system of assessment that replaced star ratings. For 16 years, he was a partner in general practice and PEC chair in a Bedfordshire PCT.

Jacqui Van Rossum, executive director integrated care (London) and transformation

Jacqui was appointed to the Board in July 2010 and has responsibility for community and mental health services in north east London.

Jacqui has over 25 years experience in operational management across community health, mental health, acute and social care. Jacqui is also a governor of the Aldborough E-ACT Free School in Seven Kings and is currently undertaking an MA in Management Practice.

Dr Afifa Qazi, Consultant psychiatrist in old age psychiatry

Dr Afifa Qazi M.B.BS, M.R.C.Psych is a consultant psychiatrist in old age psychiatry at NELFT. She is based at Goodmayes hospital where she is in-charge of running older people's inpatient services. She is involved in research in dementia at University College London and has numerous publications in peer reviewed academic journals. She is actively involved with European Association of Geriatric Psychiatry (EAGP) and is editor of the EAGP newsletter. She takes an active part in teaching and training at NELFT and supervises doctors on clinical observer-ship in old age psychiatry across European countries.

Dr Afifa Qazi is renowned in the UK and internationally for her 'Community care model for Dementia', a model of innovative practice to support GPs, care homes and community mental health team staff, that has reduced the rate of hospital admissions and length of hospital stays for people with dementia. This model was developed in Havering where Dr Qazi worked as a community based consultant before she was appointed to her current position.

Caroline O'Donnell, Managing director, North East London Community Services

Caroline qualified as a physiotherapist in 1994 and has worked locally in the north east London region as a clinician and manager. In 2005 she was appointed as the head of therapies in Barking and Dagenham PCT and was also appointed to the Professional Executive Committee as the allied health professional representative. Since then she has progressed through various management positions leading on community services redesign opportunities.

In her current role Caroline manages a range of community health services across the four London boroughs served by NELFT.

Caroline has an MSc in Physiotherapy from the University of East London and a PgDip in Quality Improvement and Leadership from Ashridge Business School.

Contact us

Telephone 0300 555 1200
For more information about NELFT and our services visit www.nelft.nhs.uk
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4 November 2013

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HEALTH & WELLBEING BOARD

Subject Heading:	Improving specialist cancer and cardiovascular services in north and east London and west Essex: a case for change
Board Lead:	Alan Steward Chief Operating Officer Havering Clinical Commissioning Group
Report Author and contact details:	Neil Kennett-Brown – Programme Director, Change Programmes – North and East London CSU

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Clinicians in north and east London and west Essex (working through UCLPartners) have recommended that specialist cancer and cardiovascular services should be reorganised to provide better care and better patient experience.

NHS England, as the main commissioner for specialised services, is leading an engagement on the clinical recommendations.

Engagement started on 28 October and is due to conclude on 4 December.

RECOMMENDATIONS

- Note the proposals and accompanying documentation
- Formal feedback on the case for change or agreement on how this will be provided by 4 December.
- While specialised services are principally commissioned by NHS England, some cardiac services are commissioned by CCGs.

REPORT DETAIL

NHS England, together with CCG partners, is considering the case for changing specialist cancer and cardiovascular services in north and east London and west Essex. This follows the engagement exercise undertaken on proposals for changing specialised urological cancer services in early 2013, after which NHS England took the decision to consider five cancer pathways and cardiovascular services together.

Clinicans (working through UCLPartners) have developed the following recommendations for how these services could be improved.

For **five complex and rare cancers**, specialist treatment would be provided in centres of excellence across the area with a key hub at University College Hospital. The vast majority of services cancer services, such as diagnostics and chemotherapy, would continue to be provided locally.

For **cardiovascular care**, services currently provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital would be combined to create a single integrated cardiovascular centre. Clinicians have recommended the centre be located in the new building at St Bartholomew's Hospital. The Royal Free Hospital and the integrated cardiovascular centre at St Bartholomew's would act as heart attack centres for the area.

Engagement on the clinical recommendations and an option appraisal process commenced on 28 October. Commissioners will then develop their recommendations for change and a business case before deciding to proceed to formal engagement in early 2014.

IMPLICATIONS AND RISKS

Financial implications and risks: NHS England are developing a business case. Initial analysis shows a positive impact to commissioners of both specialised (NHS England) and non-specialised (CCG) services.

Legal implications and risks: NHS England is following national guidance in engagement and involvement.

Human Resources implications and risks: N/A

Equalities implications and risks:

An initial equality impact assessment will be completed to inform the pre-consultation business case. A full equality impact assessment will be completed during formal engagement or consultation to inform the decision-making business case.

BACKGROUND PAPERS

Briefing
Case for Change – full version

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Title:	**Specialist cancer and cardiovascular services in north and east London and west Essex**
Date:	13 November 2012
Submitted to:	Havering Health and Wellbeing Board
Author:	Neil Kennett-Brown, Programme Director, Transformational Change Phone: 020 3688 1222 Email: neil.kennett-brown@nelcsu.nhs.uk

Executive summary

NHS England, together with CCG partners, is leading a review of specialist cancer and cardiovascular services in north and east London and west Essex. Clinicians' have developed recommendations for how these services could be improved.

Engagement on these clinical recommendations started on 28 October 2013. Following this, commissioners will develop their recommendations for change and a business case before deciding whether to proceed to formal engagement in early 2014.

Case for change

Specialist services for cancer and cardiovascular disease in north and east London are not organised in a way that gives patients the best chance of survival and the best experience of care.

Clinicians want to bring together specialists, technology and research together to provide better care and save more lives. To do that they have recommended the following changes.

For **five complex or rare cancers**, specialist treatment would be provided in centres of excellence across the area with a key hub at University College Hospital. The vast majority of cancer services, such as diagnostics and chemotherapy, would continue to be provided locally.

For **cardiovascular care**, services currently provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital would be combined to create a single integrated cardiovascular centre located in the new building at St Bartholomew's Hospital. The Royal Free Hospital and St Bartholomew's would act as heart attack centres for the area.

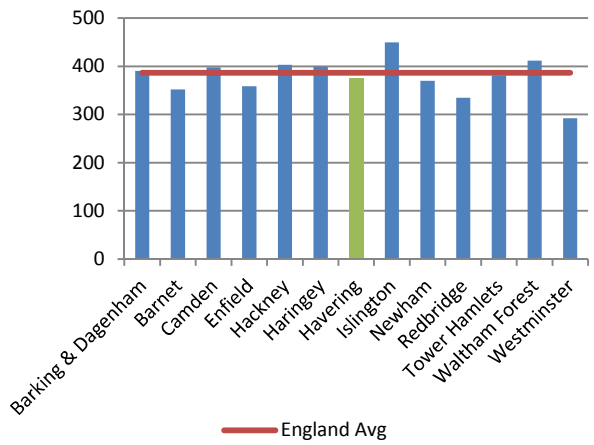
The full case for change and technical clinical recommendations will be available online at: www.england.nhs.uk/london/engmt-consult.

Cancer prevelance and mortality rates by borough

The charts below provide the incidence and mortality rates for all cancer types for Havering and surrounding boroughs.

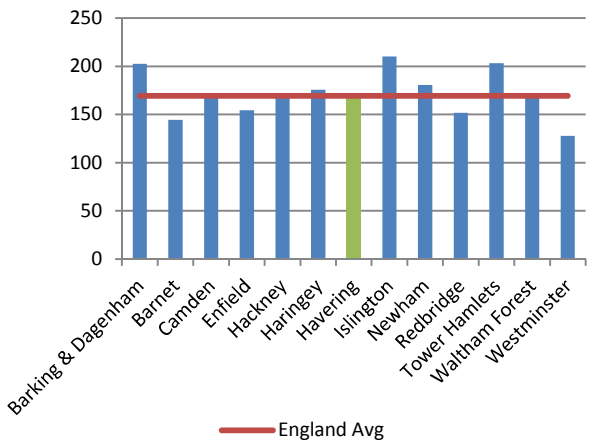
Incidence rates of all cancers (2008-10)

(Per 100,000 standard population)



Mortality rates of all cancers (2008-10)

(Per 100,000 standard population)

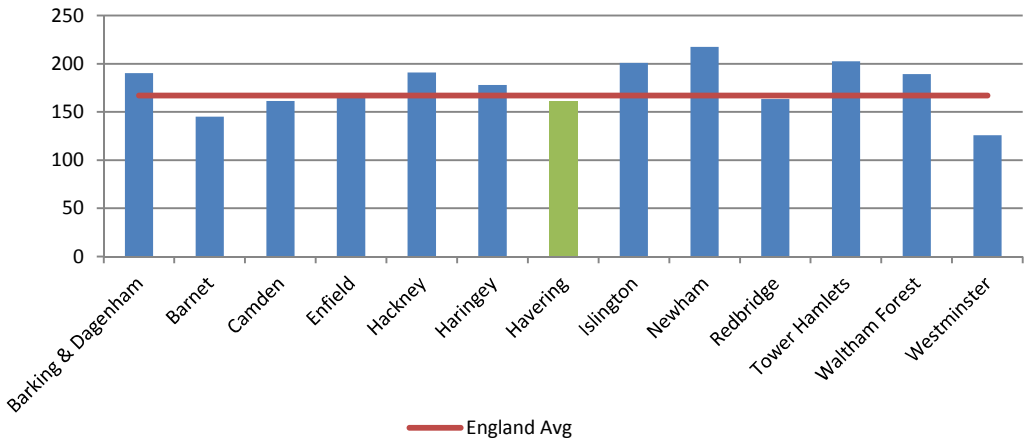


(Source: National Statistics)

Circulatory disease prevelance rates by borough

The chart below provides the mortality rates for all circulatory diseases for Havering and surrounding boroughs.

Mortality rates of all circulatory diseases (2008-10) (Per 100,000 standard population)



(Source: National Statistics)

Havering cardiac activity

The table below is intended to give a sense of the volume of patients from the area that are likely to be affected by the changes proposed to cardiovascular services.

- The table shows spells for the services affected. HRG data has been sorted into five groups representing five levels of cardiovascular activity
- The data has taken PCT data and mapped it to CCGs. There is a risk that some PCT data cannot be mapped which can lead to a slight undercounting
- Activity is shown for the three heart attack centres/cardiovascular centres in north and east London; the Heart Hospital (UCLH), the London Chest Hospital (Barts Health) and the Royal Free Hospital
- The data combines activity charged to NHS England (specialist commissioning) and CCGs

There is no data shown for the Royal Free in 2011-12. It was felt that the data on the HES system was unreliable to the extent of being misleading.

NHS Havering CCG

North East & North Central London Cardiovascular Activity

Spells	2010/11			2011/12			2012/13		
	Elective	Non-Elective	Total	Elective	Non-Elective	Total	Elective	Non-Elective	Total
London Chest Hospital									
Cardiac Surgery	63	27	90	62	33	95	37	25	62
Catheterisation laboratory	169	378	547	138	402	540	138	360	498
Routine Cardiology	14	39	53	16	45	61	1	44	46
Specialist Cardiology	1	23	24	2	23	25	1	12	13
Supra-Regional Service	5	1	6	1	2	3	4	1	5
Total London Chest	252	468	720	219	505	724	181	443	624
Heart Hospital									
Cardiac Surgery	0	1	1	4	1	5	0	0	0
Catheterisation laboratory	6	2	8	9	5	14	14	2	17
Routine Cardiology	5	4	9	2	1	3	7	4	11
Specialist Cardiology	0	0	0	0	0	0	0	1	1
Supra-Regional Service	0	0	0	1	0	1	4	0	4
Total Heart Hospital	11	7	18	16	7	23	25	7	32
Royal Free Hospital									
Cardiac Surgery	0	0	0	No Reliable Data			0	0	0
Catheterisation laboratory	4	1	5				4	1	5
Routine Cardiology	0	2	2				0	4	4
Specialist Cardiology	0	0	0				0	0	0
Total Royal Free Hospital	4	3	7				4	5	8

Source: HES

Havering cancer activity

The table below is intended to give a sense of the volume of patients from an area that are likely to be affected by the changes proposed to cancer services.

- The table shows the number of patients and not spells, so multiple spells by the same person, which is fairly common in cancer services, only show one
- The table is by borough of residence (or district for outside London) and shows activity for each of the cancer pathways that are being considered
- Activity for the last three years is shown on separate rows
- During this period the pattern of activity for some specialties has shifted. The two most significant shifts are that surgery on complex urological cancers has shifted from Chase Farm to UCLH during 2012, and neurosurgery at the Royal Free Hospital has shifted to UCLH
- The data combines activity charged to NHS England (specialist commissioning) and CCGs.

The data is not perfect; the HRG codes used for PbR do not always differentiate between the complex operations that this programme is concerned with and more routine operations that take place in most surgical departments and consequently this data is reliant on accurate procedure and diagnosis coding.

Row Labels	BARKING, HAVERING & REDBRIDGE HOSPITALS	BARTS HEALTH	HOMERTON HOSPITAL	ROYAL FREE LONDON	UNIVERSITY COLLEGE LONDON HOSPITALS	Grand Total
Brain Cancer	**82**	**10**			**5**	**97**
2010-11	26	1				27
2011-12	20	5			3	28
2012-13	36	4			2	42
Head & Neck Cancer	**21**	**51**		**2**	**2**	**77**
2010-11	7	9		1		17
2011-12	6	20		1		27
2012-13	8	23			2	34
Bladder Cancer	**13**				**1**	**14**
2010-11	4				1	5
2011-12	4					4
2012-13	5					5
Prostate cancer	**99**	**1**			**1**	**101**
2010-11	30					30
2011-12	38	1				39
2012-13	31				1	32
Renal Cancer	**48**	**6**				**54**
2010-11	15	4				19
2011-12	15	1				16
2012-13	18	1				19
Acute Myeloid Leukaemia	**19**	**6**			**4**	**29**
2010-11	5	1			1	7
2011-12	6	1			1	8
2012-13	8	4			2	14
Bone Marrow Transplants		**20**			**5**	**25**
2010-11		10			2	12
2011-12		6				6
2012-13		4			3	7
Oesophago-gastric cancer	**137**	**2**	**2**		**21**	**162**
2010-11	51				3	54
2011-12	45		2		7	54
2012-13	42	2			11	55
Grand Total	**420**	**96**	**2**	**2**	**40**	**559**

Cancer activity at BHRUT

Estimated overall change in cancer activities = -3% of cancer spells

✔ - No change ↑- Increase in activity ↓ - Decrease in activity ↓✕ - All activities moving to another site

Tumour	Referral & Diagnosis	Complex Diagnosis	Surgery & Interventional Treatment	Systemic Anti-cancer Therapy	Radiotherapy	Follow-up & Monitoring
Brain	✔	✔	↑	✔	✔	✔
Breast	✔	✔	✔	✔	✔	✔
Colorectal	✔	✔	✔	✔	✔	✔
Gynaecology	✔	✔	✔	✔	✔	✔
Haematology Other (I & IIa)	✔	✔		✔	✔	✔
AML (IIb)	✔	✔		↑	✔	✔
HSCT	✔	✔				✔
Head & neck	✔	✔		✔	✔	✔
Lung	✔	✔	✔	✔	✔	✔
Skin	✔	✔	✔	✔	✔	✔
UGI (HPB)	✔			✔	✔	✔
UGI (OG)	✔	✔	↑ then ↓✕?	✔	✔	✔
Urology Bladder & Prostate	✔	✔	↓	✔	✔	✔
Renal	✔	✔	↓✕	✔	✔	✔

No change to paediatric and teenage and young adult cancer services currently provided at BHRUT.

Engagement and scrutiny

To ensure we understand a wide range of views before developing commissioner recommendations for change, we are discussing clinicians' ideas with patient and public representatives, clinicians and staff, local councils and other groups.

We have been discussing the proposals with health overview and scrutiny committees (OSC). It is anticipated that we will engage separately with NEL, INEL and ONEL JHOSCs throughout the engagement and any formal engagement or consultation. They would then meet as a super-JHOSC at the end of the scrutiny process to consider the proposals.

We are holding public events and are welcoming the opportunity to attend local meetings.

Proposed timeline

- 28 October-4 December 2013: Engagement with stakeholders and local people on the recommendations.
- Late 2013-early 2014: Commissioners take on board local views and finalise the pre-consultation business case
- Early 2014: If appropriate, formal engagement or consultation would take place on commissioners preferred recommendations
- Mid 2014: Expected decision by commissioners on whether to proceed with changes.

- Late 2014-2018: Implementation, if approved.

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