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JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

2.30 pm	Tuesday 22 July 2014	Barking Town Hall

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Danielle Doyle
Councillor Eileen Keller (Chairman)
One vacancy

LONDON BOROUGH OF WALTHAM FOREST

Councillor Stuart Emmerson
Councillor Sheree Rackham
Councillor Richard Sweden

LONDON BOROUGH OF HAVERING

Councillor Nic Dodin
Councillor Gillian Ford
Councillor Dilip Patel

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Mark Santos
One vacancy

CO-OPTED MEMBERS:

Richard Vann, Healthwatch Barking & Dagenham
Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge
Jamie Walsh, Healthwatch Waltham Forest

For information about the meeting please contact:
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Essex County Council

London Borough of
Redbridge

Havering
LONDON BOROUGH

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. MOBILE COMMUNICATIONS DEVICES

Although mobile phones, pagers and other such devices are an essential part of many people's lives, their use during a meeting can be disruptive and a nuisance. Everyone attending is asked therefore to ensure that any device is switched to silent operation or switched off completely.

3. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

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 AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

3 DISCLOSURE OF PECUNIARY INTERESTS

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

4 MINUTES OF PREVIOUS MEETING (Pages 1 - 8)

To agree as a correct record the minutes of the meeting held on 8 April 2014 and to authorise the Chairman to sign them (attached).

5 COMMITTEE MEMBERSHIP

Following the recent elections, Members are asked to note the new membership of the Committee.

6 CANCER AND CARDIOVASCULAR PROPOSALS

To receive a presentation and update from officers from the North East London Commissioning Support Unit on the programme to change cancer and cardiovascular services for North and East London.

7 BHRUT IMPROVEMENT PLAN (Pages 9 - 52)

Presentation on the Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT) Improvement Plan (attached) from Flo Panel-Coates, Executive Director – Nursing, BHRUT.

8 BHRUT - BREAST CARE SERVICES - CHANGE OF LOCATION

To receive details of proposed changes in the location of breast care services from the Deputy Programme Director – Acute Reconfiguration, BHRUT.

9 COMMITTEE'S WORK PROGRAMME (Pages 53 - 56)

Report attached.

10 ROLE OF LOCAL HEALTHWATCH WITH THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Pages 57 - 60)

Report attached.

11 MEETING START TIMES AND VENUES

To agree the start times and venues of future meetings of the Joint Committee. Provisional meetings schedule as follows:

Tuesday 14 October 2014, Havering
Tuesday 13 January 2015, Redbridge
Tuesday 14 April 2015, Waltham Forest

(All meetings currently scheduled to start at 2.30 pm).

12 URGENT BUSINESS

To consider any item of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item should be considered as a matter of urgency.

Anthony Clements
Clerk to the Joint Committee

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MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Waltham Forest Town Hall
8 April 2014 (3.40 - 6.25 pm)

Present:

COUNCILLORS

Barking & Dagenham	Sanchia Alasia
Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light
Redbridge	Stuart Bellwood, Vanessa Cole and Filly Maravala
Waltham Forest	Khevyn Limbajee (Chairman) and Richard Sweden
Essex	Chris Pond

Healthwatch representatives present:
Richard Vann, Barking & Dagenham
Ian Buckmaster, Havering
Mike New, Redbridge

Health scrutiny officers present:
Masuma Ahmed and Glen Oldfield, Barking & Dagenham
Anthony Clements, Havering (clerk to the Committee)
Jilly Szymanski, Redbridge
Corrina Young and Farhana Zia, Waltham Forest

Health officers present:
Victoria Wallen and Emma James, BHRUT
Rylla Baker, NHS England
Dr Russell Razzaque and Fiona Weir, NELFT

45 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of action in the event of fire or other event that might require the evacuation of the meeting room.

46 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.**

Apologies were received from Councillor Syed Ahammad, Barking & Dagenham and from Jaime Walsh, Healthwatch Waltham Forest.

47 **DISCLOSURE OF PECUNIARY INTERESTS**

Councillor Richard Sweden disclosed an interest as he was employed by North East London NHS Foundation Trust.

48 **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting held on 13 March 2014 were agreed as a correct record and signed by the Chairman.

49 **BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST (BHRUT) PATIENT EXPERIENCE**

The head of PALS and complaints at BHRUT explained that there had been a large rise in the number of enquiries received by PALS. Many of these were due to issues relating to the new Trust computer system such as appointment letters being duplicated or not being received. IT solutions to address this had now been put in place. There were however still concerns about patients being able to amend appointments etc.

There had been an increase in compliments received compared to the previous quarter. The highest proportion of both compliments and complaints related to A&E. Information could also be provided anonymously on the NHS Choices website which for the first time had seen more positive than negative comments relating to the Trust. The positive comments related mainly to maternity and A&E. Negative comments related mainly to difficulties in telephoning the hospital and all comments were responded to by the BHRUT Interim Medical Director.

The overall number of complaints had risen in the last quarter although the Trust response rate to complaints had also improved in that period. It had been found that patient surveys by kiosk or hand held device had not received a large response so patient surveys were now completed on paper as this generated a larger response rate from patients.

As regards the Friends and Family test, BHRUT was achieving a score of 65 for adult inpatients and 42 for A&E. This was slightly below the target for adult inpatients and well below that for A&E. It was accepted that a lot of work was required to improve patient experience in A&E.

A lot of information for patients had been placed on the BHRUT website. A patient handbook and a bedside handbook of information were also being developed. Patients could also nominate individual staff members for recognition or pass messages and comments direct to the Matron.

Measures to improve patient experience included the appointment of two patient & staff experience facilitators who spoke direct to patients on each ward. Information was reported back to wards monthly and it was wished to increase this. Welcome boards were also being installed in each ward.

Future developments would include the introduction, as part of a national initiative, of patient headboards indicating if for example patients suffered from dementia or needed assistance at mealtimes. More easy read patient literature would also be introduced.

Following a pilot scheme, a bereavement questionnaire was being introduced which would be sent to next of kin eight weeks after a patient's death. Departments were also asked to specify what they had learnt from complaints that had been reported. Patients were also beginning to relate their stories and experiences at staff induction and training and at Trust Board meetings.

A mystery shopper programme using real patients would commence shortly. Monthly patient experience reports were produced and the previous year's survey responses were also analysed.

The BHRUT officer was aware that there continued to be complaints concerning the hospital telephone and computer systems. It was accepted that it was not possible to answer every phone call at present and further information could be provided on plans to deal with this.

It was clarified that the red tray and butterfly schemes to indicate patients who needed help with feeding or had memory difficulties would continue and that the patient headboards would be in addition to these. New methods of changing appointment via the Trust website or the PALS office were also being considered. The instances of people receiving a number of duplicate letters for the same appointment had been caused by the new Trust computer system and these had now reduced.

All enter and view reports submitted by Local Healthwatch were logged and the officer would check where these were presented to although this was believed to be BHRUT's Quality and Safety Committee.

Patients comment cards were collected weekly from the wards. A recent instance of a number of cards completed by the same individual had been brought to the attention of the Ward Sister but it had not been possible to identify the specific patient involved.

The complaints and PALS teams had recently been restructured and there were now 3.8 whole time equivalent PALS officers and 2 PALS administrators. The PALS office at Queen's was open from 10 am–12 pm and 2-4 pm and could also be contacted by phone or e-mail. People with urgent problems could be seen outside those times. The office at King George had been shut due to lack of staff but had now reopened from 10 am – 12 pm and would be open the same hours as the Queen's office within two weeks.

The Committee **noted** the presentation.

50 GP SERVICES IN OUTER NORTH EAST LONDON

It was explained by the Deputy Head of Primary Care (London) at NHS England that this was a national organisation that had commenced in April 2013 with a very broad role. NHS England was responsible for commissioning services directly and for assuring the work of Clinical Commissioning Groups (CCGs).

Core GP services i.e. those operating from 8 am – 6.30 pm were commissioned by NHS England which also commissioned community pharmacies, optometry and dental care. NHS England procured, monitored and performance managed contracts and sought to raise the quality of primary care and poorly performing GPs. NHS England was also responsible for GP premises.

CCGs commissioned secondary care such as hospital care as well as non-core primary care e.g. special GP services. The NHS 111 service was also commissioned by CCGs.

There were however a number of overlaps between the two roles such as the estate strategy which was likely to see more services located on the same sites. NHS England and the CCGs also had to agree the primary care strategy together. The primary care strategy had a number of priorities including empowering patients and the public, publishing clear quality outcomes, and developing the workforce, GP premises and IT.

NHS England expected to see GP practices working together on a bigger scale in order to achieve economies of scale. This would see more extended opening hours and the officer felt that some GP surgeries would be open until 10 pm very shortly. GP practices would also make more use of text messaging and virtual consultations. More hospital-based services would move into the community although the position would be different in each borough.

It was explained that there were a lot of part-time GPs in the sector. As more practice nurses etc were introduced, the size of a practice list normally went up. Appointments at GPs were organised by the individual practice rather than NHS England and there were no targets for numbers of appointments in the current GP contracts. Patients should make complaints initially to the GP practice. NHS England received information annually concerning the number of GP complaints but not on specific issues.

Population information was held by the public health team in each borough and was also contained in the Joint Strategic Needs Assessment for each borough. This was the same for Essex and Epping Forest and it was

agreed that the clerk to the Committee should ask NHS England for the GP statistics for the Essex area.

It was explained that NHS England arranged premises development but that NHS Property Services managed the buildings themselves and associated phone and IT systems. Many GPs had currently bought their own buildings. NHS England's view was that many GPs could not give a full service to patients due to poor premises and it was therefore better to have groups of clinicians working together. The issue should be the quality of care and health outcomes rather than the number of practices. Comments on NHS Choices and reports from Healthwatch were considered but it was difficult to performance manage under the existing GP contracts.

The NHS England representative felt that GP appointments should be able to be obtained in 24-48 hours. There were however large variations in this and it was accepted that delays in appointments had to be addressed. Details of a practice in Havering with a one-month wait for a GP appointment would be passed to NHS England by the Healthwatch Havering representative outside of the meeting. The total list sizes given by NHS England appeared to be larger than relevant borough populations and this may have been due to GPs having incentives to keep patients on their lists if they move out of the area. The list management work undertaken by NHS England was expected to have an impact on this in the next quarter. It was **agreed** that revised figures and a report on GP list sizes should be taken at a future meeting of the Committee.

If an individual GP was exhibiting poor performance, NHS England would seek to address this by drawing up an informal remedial action plan or issuing a breach notice against that contract. Cases of across the board poor performance would be worked on with the General and Local Medical Councils as well as with the Care Quality Commission. Issues such as diabetes and TB targets for GPs would be worked on jointly with the CCGs. GPs working with other practices would also influence this. It remained the choice of the GP whether to employ e.g. practice nurses.

NHS England remained unhappy that practices were not open long enough and CCGs would now commission an extra half hour of appointments for each 1,000 patients. This would aim to save patients from attending A&E if they were unable to get a GP appointment.

The NHS England officer felt that, of the for example 52 GP surgeries in Havering, this should be reduced by one third. She felt that too many Havering practices were open too few hours and that there were too many with less then 3,000 patients on their list.

NHS England hoped that the new GP contract would specify minimum standards. Members were concerned that NHS England should advise the local population of any GP closures and ensure that elderly people had a surgery nearby. There were for example two wards in Redbridge that did not contain a single GP practice. Pharmacies were commissioned by NHS

England and there was sometimes a difficult relationship between pharmacists and GPs. CCGs should be asked why GPs were not using local pharmacies. Essex pharmacies had developed a reporting scheme to improve working with GPs and it was **agreed** that more details of this scheme should be taken at a future meeting of the Committee.

Cases of duplicate registration should not occur although it was noted that, under a new scheme to be introduced from October 2014, patients would be able to register in two places. It was confirmed that primary care services were free to all at the point of contact and that overseas visitors could access primary care services without the need for a visa etc.

Patient Participation Groups were paid for by the respective practices and NHS England felt it was important that these groups continued to have an influence. It was **agreed** that a recent Waltham Forest scrutiny report on GPs would be circulated to the Committee.

The Committee **noted** the presentation.

51 MENTAL HEALTH SERVICES IN OUTER NORTH EAST LONDON

The NELFT representatives explained that access to hospital mental health in-patient services was normally via the NELFT home treatment teams. The establishment of teams had led to a reduction in the number of admissions to hospital. With effect from May 2014, NELFT would also be responsible for adult duty emergency services. There was a rising demand for referral into mental health services.

Mental health assessment opening hours were being extended in Waltham Forest and it was hoped do the same in the other NELFT boroughs. Psychiatric liaison services were accessible from the three local acute hospitals and it was aimed to direct mental health service users away from A&E.

Outpatient clinics were no longer used but community multi-disciplinary teams were used to offer short-term interventions. For older adults, the memory service was in place across the four boroughs. There were also strong links with the Alzheimer’s Society and other groups. Work was also in progress with Admiral Nurses in three boroughs and with the third sector with initiatives such as the Alzheimer’s Café.

It was explained that the work of the home treatment teams had led to only needing a low bed base in acute wards. There were two female 20-bed wards and three male 20-beds wards as well as a psychiatric intensive care unit. Female intensive care beds were spot purchased as required. Two complex recovery wards covered the four boroughs. Specialist in-patient

services included Moore ward comprising 12 beds for patients with learning disabilities and Brookside – a tier 4 in-patient unit for young people. There remained two female and two male wards for older people.

Emergency mental health admissions via the police were conducted under section 136. There were two suites for this at Sunflowers Court where staff were available to carry out assessments. Once assessments were completed, patients would be moved to wards.

It was the case that there was no statutory requirement under some forms of section for patients to continue to be supervised after their release. There would however normally be some monitoring of these cases by the community recovery teams. The key was to ensure monitoring and stabilising of people in the community.

In-patient detox services were no longer commissioned but each borough had its own substance misuse services. It was confirmed that some psychological services continued to operate at Thorpe Coombe in Waltham Forest. The NELFT officers would supply further information concerning continuing care for older people in Waltham Forest.

The IAPT (Improving Access to Psychological Therapies) team was a primary care service. The team operated by phone or face to face but contacts were mainly by phone and allowed specialised cognitive behavioural therapy for depression or anxiety. The service was accessed by self-referral although information could also be given a person's GP. Details on accessing the service were also available on the NELFT website.

Budgetary information was given in the NELFT annual report and the Trust was required by Monitor to retain a certain level of reserves.

The Committee **noted** the presentation.

52 INFORMATION ITEM: OUTCOME OF REVIEW OF PROSTATE CANCER SERVICES PROPOSALS

The Committee noted that the report of the review by the London Clinical Senate into the proposals for changes to services for prostate cancer had been delayed and was now expected to be available towards the end of April. It was agreed that the clerk to the Committee should circulate this to all Members once it was available.

53 URGENT BUSINESS

The Committee was addressed by a representative of a patients' group in Essex concerning the cancer and cardiac proposals following a recent decision by the Essex Health Overview and Scrutiny Committee to refer the group to the Joint Committee. The representative felt that the views of

Essex residents, particularly as regards access to alternative facilities under the proposals, had not been sufficiently taken into account and that mandatory, full public consultation should take place.

Members noted the address and sympathised with some of the views expressed. It was pointed out however that the Joint Committee had already reached a decision on the proposals and this included a strong recommendation that scrutiny of all aspects of the plans should continue as they were implemented.

The Committee **agreed** to note the continuing discontent with the cancer and cardiac proposals in the Essex area.

It was suggested that the Committee should review GP contract arrangements at a future meeting.

The Chairman stated that the work of the Joint Committee had been very valuable and recorded his thanks to the Committee Chairmen from the different boroughs and to the officers supporting the Committee.

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Chairman

Barking, Havering and Redbridge University Hospitals NHS Trust

NHS

unlocking our potential

our improvement plan for 2014/15

taking **pride**
in **improving** the
care we provide to
local **people**

FINAL

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Introduction

Unlocking our potential: our improvement plan

The 6,000 people that make up BHRT, have a very simple purpose – to provide high quality, compassionate care and treatment for our local communities.

We have a clear picture of how we want our services to run in the future for the 700,000 local people who rely on us for care, treatment and support, whether this is planned or in an emergency.

We want to provide high quality care as standard across our two sites. We want high performing maternity and emergency services that can be relied on 24/7. We want patients to receive prompt surgery when they need it, with the best possible outcomes and returning home as soon as possible.

In many cases we do this well, and there are many positive things about the services that our staff provide which should be celebrated. We are, however, alert to the enormous challenge that we face to achieve this on a consistent basis across all our services, at all hours of the day and all days of the week.

The recent inspection by the Care Quality Commission (CQC) has given us cause to pause, reflect and refocus. We are determined to work with our staff to deliver the change that we all so passionately want to see for the people we serve, and to become a more credible and effective partner in our local health and social care economy.

To do this, we need services to be provided where they have the best impact, whether at Queen's, King George or in peoples' own homes in the community. And, reinforced by the Francis report into Mid-Staffordshire Hospital and the Keogh reviews into mortality, emergency care and seven day working, there is a need to make sure our services are of a consistently high standard for patients.

This means working closely with local GPs and councils to play our part in coordinating home care. We also need to work closely with hospitals across London so our patients have rapid access to additional specialist skills, expertise and technology should they need it.

At this point in time, we are some way off achieving this vision. The Trust has a number of significant barriers, some clinical, some financial and some organisational, to overcome first.

Whilst some of these are long-standing and complex, and some cannot be solved by us alone, we can and must make significant progress ourselves. These challenges come on top of the need to meet increased demand for our services and make more of limited national NHS resources.

Following their inspection, the CQC recommended that the Trust be placed into special measures, publicly recognising and reinforcing that the Trust must make significant improvements. Particular areas of focus centred on our emergency pathway and our overall organisational structures and processes to oversee and drive improvement in the quality of services.

This plan sets out what we will do to meet these challenges. Importantly, the special measures regime gives us the opportunity, and the support from across the NHS and with partners, to address these issues once and for all.

We are grateful to our partners for the support they are providing to us. Our plan reinforces and supports the strategic objectives of our coalition of partners, especially our objectives of transforming emergency care and developing our workforce. This plan, and its implementation, will play a major

role in achieving the aims of our local GPs and local authorities to improve healthcare for our local communities.

Delivering our plan will not only see immediate improvements in our services, but they help us take the longer term steps needed to truly unlock our potential. For example, improving our emergency department will benefit patients in the short and medium term, and will allow us to move forward with the confidence of our staff and partners to make the larger strategic changes already agreed but delayed by our current performance. Progress will help us to secure more investment and attract the permanent staff we need. This will be difficult but only by doing so, will other benefits flow. This plan sets out what must be done, how, by whom and by when.

Executive Summary

The Care Quality Commission (CQC) inspection took place from the 14th – 17th October 2013 and the Trust was the second in London to be scrutinised under the new inspection model. The final CQC report was published in December 2013.

The CQC have five themes against which they assess services – safe, effective, caring, responsive and well led. The full reports are available on the CQC website (http://www.cqc.org.uk/directory/rf4). This section provides a summary of their findings about services at Queen's Hospital and King George Hospital.

1. Ensuring services are safe

The CQC said: Many of the services are safe but require some improvements to maintain the safety of patient care. The A&E department at Queen's Hospital is at times unsafe because of the lack of full-time consultant and middle-grade doctors. There is an over-reliance on locum doctors with long waiting times for patients to be assessed by specialist doctors. Other services such as medicine and surgery require improvement.

2. Ensuring services are effective

The CQC said: The trust had some arrangements in place to manage quality and ensure patients receive effective care, but more work is needed in medicine, end of life care and outpatients. Effective care in the emergency department is hampered by long waiting times for patients to be seen by a specialist.

3. Ensuring services are caring

The CQC said: National inpatient surveys have highlighted many areas of care that need improvement and work has been undertaken to improve the patient experience. Significant work has been undertaken to improve patient care and many patients and relatives were complimentary about the care they received and the way staff spoke with them. We observed that staff treated patients with dignity and respect. However, more work is required to improve care in the end of life service and ensure improvement in patient care in all services is reflected in national patient surveys.

4. Ensuring services are responsive

The CQC said: The longstanding problem of waiting times in the emergency department at Queen's Hospital has not been addressed. Poor discharge planning and capacity planning is putting patients at risk of receiving unsafe care and causing unnecessary pressure in some departments. A lack of effective partnership working with other health and social care partners has contributed to the problems.

5. Ensuring services are well led

The CQC said: We found examples of good clinical leadership at service level and staff were positive about their immediate line managers. The trust Executive Team need to be more visible and greater focus is needed at Board level to resolve longstanding quality and patient safety issues.

Our Improvement Plan approach and structure

We have focused on five improvement themes to strengthen the safety, effectiveness, care and responsiveness of our services whilst improving how we lead and develop our organisation.

Here is a summary of the themes and the main objectives we will be focusing on:

Workforce: recruiting, retaining, developing and deploying the right numbers of permanent staff we need to provide high quality care 24/7

Our objectives are to increase the number of A&E senior medical staff , attract more permanent staff to work here and keep them for longer.

Patient flow and emergency pathway: making sure our patients are assessed and treated promptly and are supported to return home as soon as they are medically fit to leave hospital, and to ensure that patients having planned care are treated in an appropriate environment and have the right follow up care

Our objectives are to improve the way we assess people when they come to hospital, and to work with our community services to significantly improve the pathway for frail older people. We will reduce admissions, and ensure people do not spend avoidable time in hospital by changing processes, behaving as one team across organisations and making better use of community services to provide care and assessment that currently takes place in an acute bed. We will support this with a new model of clinical care for patients who do need to be in acute beds, being seen daily by a consultant 5 days a week and moving to 7 days a week across more wards when we concentrate care on one site.

Patient care and clinical governance: supporting all our care with effective management of patient notes, information and with systems which alert us quickly to problems.

Our objectives are overhaul our clinical governance arrangements and the way in which we ensure services are effective through better use of information and increased visibility in frontline departments. We will also improve outcomes for patients by giving training to our staff to diagnose and treat sepsis.

Outpatients: ensuring effective management of our outpatient services so they run on time, every time

Our objectives are to overhaul the way we plan and manage outpatient appointments to make them more effective. For day care surgery, we will improve the environment, reduce the number of cancelled operations and improve care for patients after surgery.

Leadership and organisational development: putting the right systems, structures, checks and balances in place to make sure our Trust is properly managed from Board to ward.

Our main objectives will be agreed shortly by the new Chief Executive who takes up their position in April 2014.

Many of the improvements that need to be made are the responsibility of the Trust. However, one of the major areas for improvement is the emergency care pathway. For this area, successful improvement needs our actions to fit into the health economy strategy and also needs the support of partners. The relationship between the improvement plan and the health economy strategy is described in the patient flow section, and the support required from partners is summarised in section 6 – 'delivering the improvement plan'.

unlocking our potential

section one – workforce

our improvement plan for 2014/15

Improving our permanent workforce

Why this is important

Providing high quality services requires us to have the right number of staff with the right skills in each of our departments. A stable, largely permanent workforce drives up quality because people working in our hospitals understand our ways of working, build positive relationships with the local communities and share a stake in our future success.

The CQC found that:

- Morale amongst our 6,000 staff has improved and their inspectors received positive feedback on the care our staff provides to patients
- Long-standing difficulties in recruiting permanent staff are having an impact on the effectiveness and safety of our services across both sites. There is an over-reliance on locum and temporary staff that impacts on patient care. This is particularly the case in A&E where there are not enough consultant or middle grade doctors, but is also a problem in some other specialties too.
- Ineffective compliance and shift rota management systems are leading to a poor deployment of permanent staff and there is no central oversight for management of ward staffing levels and the use of temporary or locum staff.

Our assessment of the key issues:

The workforce challenges we face are driven by a number of issues:

- The Trust's long-standing challenges have led to a reputation that does not encourage enough people to choose it as their preferred place of work. This is particularly the case for junior and senior medical roles within the Trust, but also applies to nurses and some therapy roles.
- Doctors in training do not always have a positive experience, usually because of perceived high workloads, and a lack of consistent clinical supervision and training from senior medical staff. This can discourage doctors from choosing to work here. However, many trainees who have worked at our hospitals speak very positively about the level of pathology that they are exposed to at the Trust and the learning opportunity this provides.
- The challenges facing the organisation (in particular those arising from the emergency pathway) result in high turnover which negates the impact of recruitment. This is compounded by other local hospitals paying their staff inner London weighting which we are not able to provide because of our location. For example, exit interviews showed 20% of nurses leave for the same grade job in another Trust because they receive higher pay and believe they will have a better experience
- There has been a lack of coordinated oversight of workforce levels and the mix of temporary and permanent staff. Some systems are in place, e.g. eRostering & eJobPlanning but are not fully utilised.
- Job planning for medical staff has been less effective and has not been implemented in a way that reflects the Trust's needs and priorities and desired working models.

Our improvement objectives are to:

1. Increase the number of A&E senior medical staff through improved recruitment, training and job design
2. Strengthen and diversify our workforce model by developing our non-medical A&E workforce
3. Improve the oversight and deployment of our workforce on both a strategic and shift by shift basis
4. Improve our overall recruitment processes to reduce our reliance on locum, bank and agency staff
5. Ensure clinical directorates and HR have a shared objective to improve recruitment and retention.

Our priority actions that will deliver the biggest impact are:

Objective one: Increase the number of A&E senior medical staff through improved recruitment, training and job design

1.1 Through improving the patient flow (which is described in section two) we will seek to make the A&E department a more attractive place to work, and we will reduce the requirement for A&E senior staff through consultants in Elderly Medicine and Acute Medicine undertaking the initial assessment and treatment of a group of patients who are currently the responsibility of A&E

1.2 We will aim to improve recruitment to A&E consultant posts by creating rotations with other Trusts, such as Barts Health, to make the posts more attractive, and will assess the feasibility of creating an academic post at BHRT.

1.3 Our local education and training organisation (LETB), health education north central and east London, will implement new rotations for specialist registrars with our hospitals forming part of 5 out of 9 rotations, and with rotations redesigned to link the significant training opportunity at Queen's with more sub-specialist opportunities in other hospitals. More senior trainees will be placed at Queen's.

1.4 We will create a local parallel training programme for the 18 non-training grade posts that we have filled to maximise retention. We will evaluate the success of this and consider further overseas recruitment.

1.5 We will, with the LETB, create 4 new training posts in A&E and acute medicine by establishing an acute care common stem training programme at Queen's Hospital.

Objective two: Strengthen and diversify our workforce model by developing our non-medical A&E workforce

2.1 We will train 4 advanced nurse practitioners and 7 emergency nurse practitioners to develop an alternative and more consistent workforce to A&E doctors, as part of the overall A&E senior clinical decision making workforce.

Objective three: Improve our recruitment processes and attract more people to work at BHRT

4.1 We will engage specialist support and will work with partner organisations to better promote the opportunities at the Trust, and the local area.

4.2 We will run targeted national and international recruitment campaigns, will regularly recruit to take account of turnover and will guarantee our local student nurses who achieve their competencies jobs within the Trust.

Objective four: Improve our retention of people who join BHRT

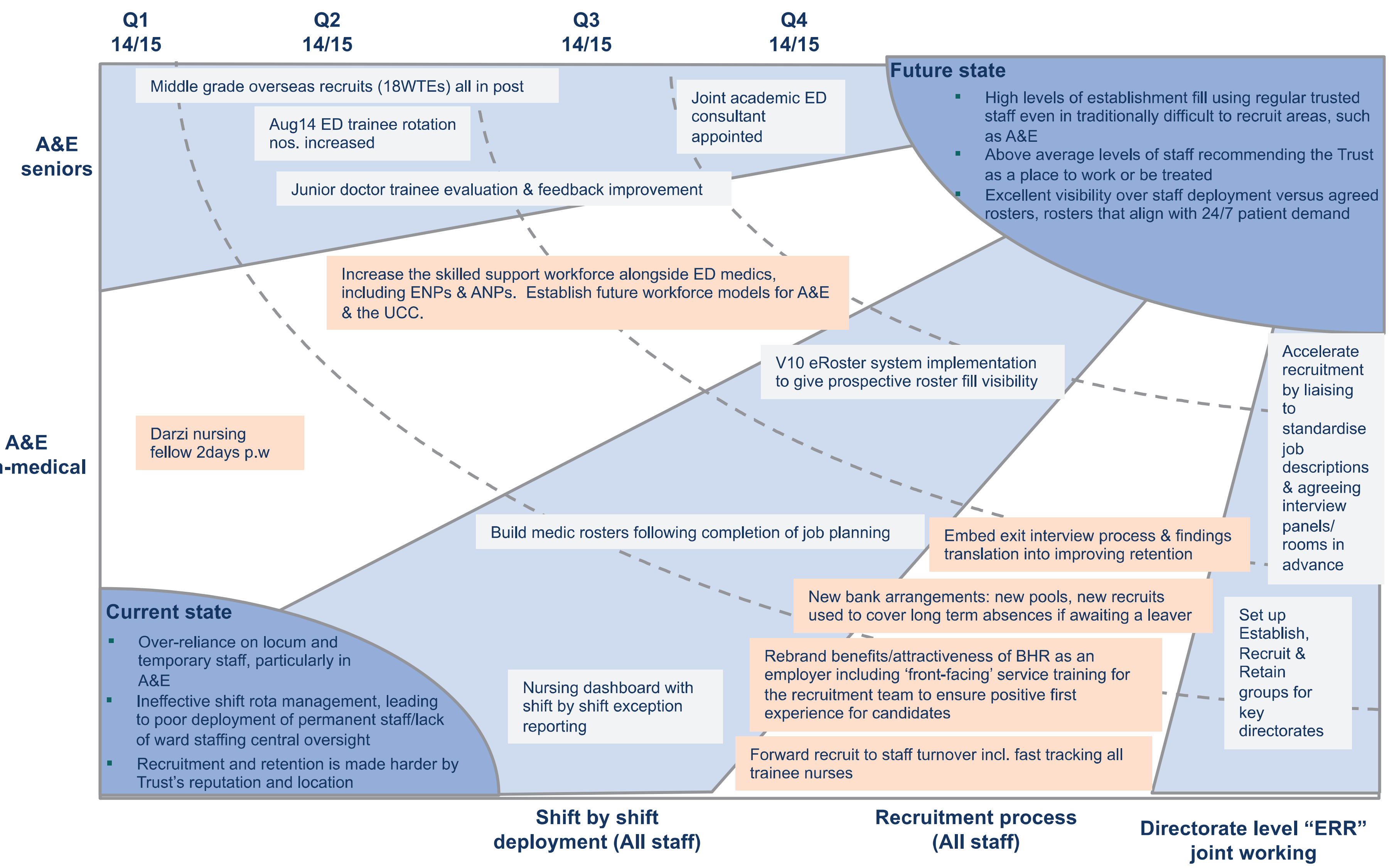
5.1 We will improve our exit interview process and will work with staff side partners to reduce the number of people who leave the Trust.

We will know we have been successful if:

1. Vacancies in permanent doctors or doctors in training fall from 13 Consultant posts and 18 middle grade posts to 5 and 5.
2. We have 4 ANP and 7 ENP nursing staff in post, working independently.
3. We increase the number of appointable applicants for posts we recruit to.
4. The proportion of our posts filled by permanent staff rises from 87% to 89%.
5. Staff turnover across the Trust falls to no more than 10%, particularly within the Emergency Department and amongst qualified nurses, which experience rates of 20%.
6. Staff recommending the Trust as a place to work or be treated, as reported in the staff survey, improves from 3.55 out of 5 to at least 3.7 out of 5 (i.e. from a below average to an above average score).

A summary of the actions we are taking to move towards achieving our future state is shown on the following page and the detailed actions are shown in Appendix 1.

Workforce improvement plan on a page



Barking, Havering and Redbridge University Hospitals NHS Trust

unlocking our potential

section two – patient flow

our improvement plan for 2014/15

2.1 A&E department and acute assessment
2.2 Discharge from hospital
2.3 End of life care

Introduction: There is a health economy strategy in to which the improvement plan fits, and can accelerate delivery of the strategic objectives

The BHR economy is made up of partners from Barking and Dagenham CCG, the London Borough of Barking and Dagenham, Redbridge CCG, the London Borough of Redbridge, Havering CCG, the London Borough of Havering and Barking, Havering and Redbridge University Hospitals NHS Trust and North East London NHS Foundation Trust.

The integrated care coalition, which is made up of all these organisations, is the vehicle for collectively building a sustainable health and social care system.

The coalition is placing a particular priority on driving improvements in the pathway for frailty and long term conditions, as people in this pathway have the most health and social care needs and are consequently are the greatest users of health and social care from an emergency care perspective.

Transforming the emergency care pathway and transforming our workforce, are the major priorities for the coalition, and there are clear strategic objectives that describe the future vision for emergency care across BHR, in which the improvement plan actions sit.

This section describes how the improvement actions associated with the emergency care pathway fit into and accelerate delivery of these strategic objectives.

Our improvement objectives	Which will result in
1. People at risk of an unplanned admission to hospital will be identified and care plans put in place proactively to prevent their condition deteriorating.	Fewer emergency admissons to hospital and fewer acute bed days
2. For people who do need urgent care, there will be alternatives to admission to a hospital bed to maximise the likelihood of them being treated in an ambulatory or home setting.	Fewer emergency admissons to hospital and fewer acute bed days
3. For people who do need admission to hospital, avoidable time in an acute hospital bed will be eliminated.	Fewer acute bed days
4. For people who have ongoing care needs at the time they leave hospital these will be delivered in their own homes as the default to reduce avoidable admissions to community beds and nursing and residential care.	Fewer admissions to nursing and residential homes, fewer community bed days
5. For people who have been admitted to hospital there will be interventions put in place to support them after discharge to prevent avoidable readmissions	Fewer emergency readmissions to hospital and fewer acute bed days
6. For people who are at the end of life, they will have advanced care plans put in place and they will be cared for in their preferred place.	Fewer emergency admissons to hospital and fewer acute bed days

Delivering these objectives will result in an emergency care system in which the default is care at home, rather than care in a hospital bed and will ensure that the acute hospital capacity is only used for patients who need that level of care.

Building blocks have been put in place in the community

In 2013/14 a number of community based services were put in place as the building blocks for the out of hospital enablers to support the new model.

1. Intensive Case Management (ICM), built around groups of GP practices – system objective 1
2. Community Treatment Team (CTT) – system objective 2 and 3
3. Intensive Rehabilitation Service (IRS) – system objective 4

The Trust's and partner organisation improvement actions fit into the health economy strategy, build on the interventions to date and will accelerate delivery of the strategic objectives

The improvement plan will support the delivery of the health economy future model of care in a stepped way.

1. By stabilising the current emergency care pathway, putting in place significant changes to the clinical operating model at the 'front end' of the pathway

2. Through the new clinical model joining up with the community based schemes and operating as 'one team' to start the more radical shift of services to the new model of care.

3. Through responding to the reduced demand, driven by a concerted hospital and community effort, by consolidating and reducing the current acute bed base onto the Queen's site and rebalancing the organisation to one in which there is a greater focus on specialist out-reach and support to manage patients in alternative care settings.

The improvement plan has actions for the Trust and partner organisations which fit with each of the 6 key objectives and provide the opportunity to create a fully integrated 'end to end' frailty pathway.

The three areas of focus – A&E and acute assessment, discharge and end of life care describe the improvements that will be made, and the relationship to the strategic objectives is shown on page 23.

Improving patient flow – Accident and Emergency Department and Acute Assessment

Why this is important

Last year, there were over 220,000 attendances at our Accident & Emergency (A&E) departments and we admitted 59,000 patients to hospital. The NHS constitution sets a standard that 95% of people should be seen, treated and admitted or discharged within four hours of entering our emergency departments.

There is evidence that shows that people who wait longer than four hours in A&E have a higher risk of mortality and have higher lengths of stay in hospital. Overcrowded departments can result in the risk of treatment being delayed with patients being managed in the wrong clinical area.

The CQC found that:

- Patients were not always receiving timely and proper care because of major delays in their assessment and treatment
- Patients were waiting too long to see a specialist doctor when they had been referred by an A&E clinician, and were waiting too long to move to a hospital bed
- The pathway for children un-necessarily delays their initial assessment.

Our assessment of the key issues:

- Whilst there are some challenges at King George Hospital, the major issues are at Queen's Hospital, and the improvement actions largely relate to Queen's Hospital.
- We currently admit around 65 to 75 patients to General Medicine at Queen's Hospital each day, for which there should be a total of just over 110 of our beds that we dedicate to assessment and short stay. We currently run 64 of our beds in this way. This means that short stay patients are admitted into the main hospital bed base, and may stay in hospital longer as a consequence
- The current pathway is 'serial' in nature and patients have a review from a senior physician only at the very end, after the patients have already often spent a large amount of time in A&E being clerked by A&E doctors and then referred to medicine, to then be reviewed by another junior doctor
- Patients are often not seen by a consultant on the day that they are admitted to hospital because of the length of the process leading up to consultant review and the length of time that consultants are present on the assessment unit
- There are insufficient alternatives to admission, such as 'hot clinics' and ambulatory care which are not available on a daily basis.
- A recent audit showed that around 35 of the patients we admit each day met a frailty score indicating they would benefit from specialist assessment and treatment by geriatricians. We currently have 10 frailty beds within the MAU. This means the right clinicians are not assessing many frail patients.
- 40% of patients who spend more than 4 hours in our departments are discharged from A&E. Many of these are out-of-hours. This is in part because the A&E workforce is overloaded, and is devoting considerable time to patients who are admitted to another specialty, and partly because of a lack of senior presence out of hours.
- There are community services in place which could be utilised for more patients to care for them in their own homes.

Our improvement objectives are to:

1. Improve the assessment and treatment within A&E
2. Create a new pathway for frail older patients so they are assessed by a specialist team outside of A&E so patients are discharged sooner
3. Strengthen the links between the new frailty service and community services to prevent patients being admitted, and to support more care being delivered at home
4. Increase the number of patients treated in an alternative care setting rather than being brought to A&E by working with London Ambulance Service and our Community Service partners
5. Create a new initial assessment and short stay pathway for adult medical patients so they are first seen by a Consultant or Specialist Registrar outside of A&E and are discharged sooner
6. Improve the paediatric A&E pathway.

Our priority actions that will deliver the biggest impact are:

Objective 1: Improve the assessment and treatment within A&E

1. We will create an observation unit at Queen's Hospital to treat patients who need observation and treatment for up to 6-8 hours
2. Develop the Urgent Care Centre to function as a distinct service 24/7 to reduce the pressure on the main department, staffed by a dedicated team of emergency nurse practitioners to create a more consistent workforce
3. We will provide more dedicated paediatric consultant support and leadership to the children's A&E.

Objective 2: Improve the pathway for frail older patients, and reduce the volume of activity in A&E

4. We will change one of our current admission wards into a frailty unit and patients will be assessed in the unit, rather than in A&E, by a Senior Clinician as they present (known as an 'on take model')
5. Community services (CTT, IRS and ICM) will support this and the elderly short stay ward to discharge more people home
6. We will implement daily ambulatory clinics as an alternative to acute admission, and to support discharge
7. We will run a pilot to assess patients in their own homes rather than at hospital with remote support provided by the specialist consultant team.

Objective 3: Improve acute assessment for adults, and reduce the volume of activity in A&E

1. We will create a 'medical receiving stream' so that stable medical patients are transferred directly to the unit, and assessed by an Acute Medicine specialist, removing the step of assessment by the A&E medical staff
2. The consultant presence will be extended to 10pm, to ensure that more patients are seen by a consultant on the day of their presentation
3. We will implement daily ambulatory clinics as an alternative to acute admission, and to support discharge.

We will know we have been successful if:

1. The median time to assessment by an appropriate decision maker is 60 minutes or less
2. 95% of medical patients have their initial assessment by a senior physician within 30 minutes of referral from A&E
3. 95% of patients stay in the assessment area for 12 hours or less
4. 50% empty capacity at 8am in 18 trolleyed Medical Assessment Space (95% achievement over rolling 7 days) and capacity of at least 9 assessment trolleys at 8am
5. 50% of patients are discharged within 24 hours of arrival to MAU short stay and 85% are discharged within 48 hours of arrival to MAU short stay short stay beds
6. 95% of patients who meet the frailty threshold are admitted to the frailty assessment unit within 30 minutes of referral
7. There is improved patient experience measured through the Friends & Family Test and staff survey results within ERU and Short Stay MAU.

The next section sets out the changes that we are making to improve discharge and reduce occupancy in the hospital which is critical to improving the overall emergency pathway. A summary of all the actions we are taking to improve patient flow is shown at the end of this section on page 22 and the detailed actions are shown in Appendix 1.

Improving in-patient care and discharge from hospital

Why this is important

We know that patients want to go back to their usual place of residence as soon as they are well enough to do so. A well-managed discharge from hospital supports patients to recover and regain their independence more quickly.

Patients want to be supported once they are at home to check they are coping and to allay any concerns that might lead to readmission to hospital on an unplanned basis. In turn, this enables us to admit patients who are medically unwell to the hospital by ensuring that beds are not occupied by patients who are able to have their care needs met outside of an acute hospital.

Ensuring that only patients who need to be in an acute hospital bed are cared for in those beds means that the hospital will need fewer beds overall, which in the medium term will allow in-patient care for emergency admissions to be focused on a single site and will mean that we can provide better quality with a smaller permanent workforce, meaning that we will no longer have big gaps in our workforce filled by temporary bank and agency staff.

The CQC found that:

- There were delays in patients being discharged, because of hold-ups in doctors completing discharge summaries, long waits for medication to take home and delays in putting care packages in place
- There were patients who were assessed as fit for discharge but were delayed because of a lack of community capacity or delays in arranging support for them
- Occupancy in the hospital was too high, and the discharge arrangements need a whole system review
- Some patients were not discharged from ITU when they could be stepped down to a ward because of a shortage of available beds, which sometimes resulted in patients who needed ITU being nursed elsewhere
- Patients were being nursed in recovery because of bed shortages, which is an inappropriate environment and led to operations being cancelled
- There was not clear monitoring of length of stay to identify specific blockages and when and why they occur
- Improvements were needed in ensuring patients are cared for on the appropriate ward
- Seven day working was not embedded as job planning had not taken place to enable consultants to be on the ward seven days a week.

Our assessment of the key issues:

- Patients remain in hospital beds despite being medically fit for discharge due to delays in completing the appropriate paperwork correctly first time - this includes social service referrals for packages of care, fast-track for end of life care and electronic discharge summaries
- The processes on the wards for prioritising discharges earlier in the day and ensuring that appropriate actions are being taken to expedite discharge are not consistent; therefore very few patients are discharged before midday. Productive Ward Round best practice is not rolled out or embedded across the medical wards to support timely and earlier discharges to improve patient flow.

Our improvement objectives are:

1. To reduce avoidable time in hospital
2. To improve capacity planning

Our priority actions that will deliver the biggest impact are:

Objective 1 – reduce avoidable time in hospital

1.1 Implement a new medical model for in-patient wards and roll out the Productive Ward Round model to all multidisciplinary teams with a consultant review of all patients each day, consistent junior doctor cover and tasks associated with discharge completed in real time rather than batched
1.2 Implementing a 'trusted assessor' model so that patients are only assessed once, and only when required
1.3 Move to a model of 'discharge to assess' through the community based services (IRS and CTT) and streamline and prioritise the paperwork requirements to support discharge
1.4 Broaden the criteria for rehabilitation beds, moving them to sub-acute beds, with the intensive rehabilitation service working to support these patients at home more rapidly
1.5 Improving the effectiveness of our discharge and transfer processes through the Joint Assessment & Discharge (JAD) Team
1.6 Eliminating delays for in-patient diagnostic tests
1.7 Implement LACE scoring to identify patients at risk of readmission and implement the evidence based community and primary care interventions to ensure people are supported in their own homes 30 days after discharge.

Objective 2 – improve capacity planning

2.1 Undertaking regular evidence based audits to show our effectiveness of reducing avoidable time in hospital and using the results to drive change across the health and social care economy.

We will know we have been successful if:

1. There are at least two discharges per medical ward before midday across both sites i.e. 10% of daily discharges before midday, and hospital occupancy drops to 95%
2. Length of Stay (LOS) for medical wards reduces by at least one day
3. Re-admissions reduce from current position of c6.8% towards the improvement trajectory of 4%.
4. The number of avoidable days in hospital identified in the utilisation review reduces to 5-10%

The next section sets out the changes that we are making to improve end of life care which is important to improving the overall emergency pathway because at the present time too many people are not effectively supported to die at home.

A summary of all the actions we are taking to improve patient flow is shown at the end of this section on page X and the detailed actions are shown in Appendix 1.

Improving end of life care

Why this is important

Our primary goal is to help people recover from illness or injury, but when someone reaches the end of their life we want to ensure that people are made comfortable, treated with kindness and respect and that they are supported to die in their preferred place. The majority of people (75%) say that they would prefer to die at home.

The CQC found that:

- Some patients and families at KGH felt they were not fully involved in end of life arrangements, with not enough support and guidance from the palliative care team
- the ease of attending palliative care training, and the numbers of staff doing so, raised the possibility of variability of care across wards
- there were delays in supporting patients through the fast-track process. There were weekend referrals to the palliative care team which could not be completed until Monday because the team was only available Monday to Friday. Care packages are not always delivered on time due to the length of time it took to complete the referral form and information sharing, particularly over weekends.

Our assessment of the key issues:

- Too many people die in hospital in BHRUT. The latest SHMI data shows that 76% of people die in hospital. This shows that we are in the bottom third for supporting people to die at home who are admitted to hospital and die within 30 days of that admission
- An audit showed that 85% of patients who are considered for 'fast-track' discharge are supported by the specialist palliative care team, with the remaining 15% managed by ward teams. The average time to complete the fast-track paperwork was seven days for those managed by the specialist team and 12 days for those managed by the ward teams. The completion of the paperwork is therefore taking too long
- The national standards for rapid discharge of end of life patients are within 24 hours. The current process requires paperwork to be completed and sent to the Brokerage Team for ratification which takes up to 48 hours, making it difficult to meet national rapid discharge standards. Paperwork required currently consists of four components; National Tool, Care Plan (this is part of the tool, however a London Wide initiative requires the Care Plan as an additional document), medical report and signed consent form. We will work with our partners to streamline requirements whilst meeting statutory requirements for fast track paperwork
- An audit of 32 fast-track applications for January showed that 63% were approved by the CCG the same day, and 10% within 24 hours. 21% were ratified after 48 hours – and these all related to applications submitted on Fridays or over the weekends as there is no cover from the CCG Brokerage team over the weekend.

Our improvement objectives are:

1. To reduce the number of people who are admitted to hospital at the end of their life
2. Improving the care for people when they are in hospital and at the end of their life
3. To eliminate avoidable time in hospital for patients who are admitted to hospital and want to be cared for at home.

Our key priority actions that will deliver the biggest impact are:

Objective 1: Reduce the number of people admitted to hospital and the end of their life

1.1 Working with partners to implement advanced care planning and the gold standards framework to support more patients to die at home.

Objective 2: Improving the care for patients in hospital

2.1 Raising staff awareness through relevant training in more accessible formats
2.2 Providing specialist palliative care cover 7 days a week.

Objective 3: Avoiding time in hospital when patients want to cared for at home

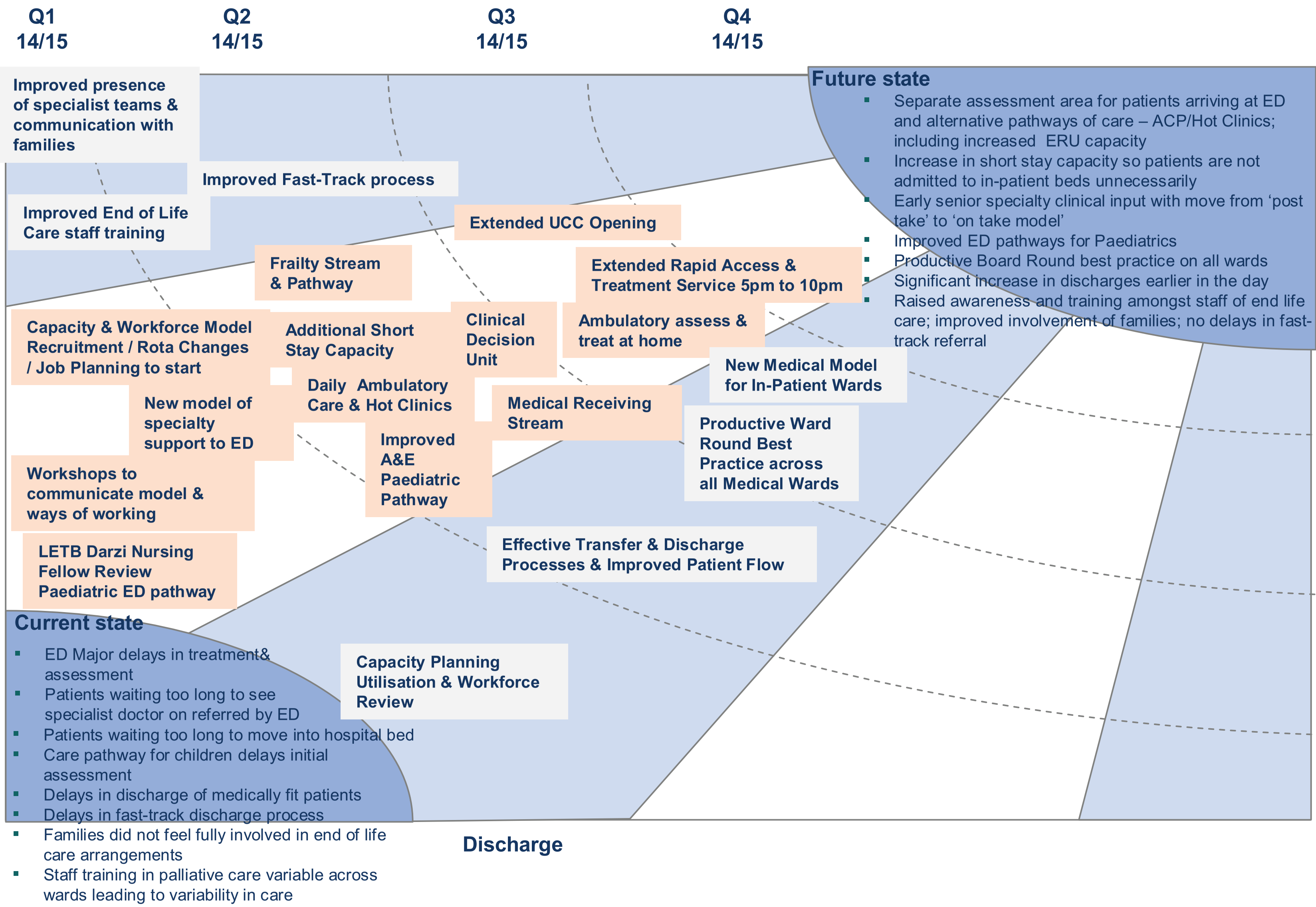
3.1 Providing specialist palliative care team input across the Trust seven days a week and providing patients and their families with a named contact who will manage their pathway at end of their life so patients die in their preferred location
3.2 Streamlining requirements whilst meeting statutory requirements for fast track paperwork through work with our partners
3.3 Implementing a brokerage system at weekends.

We will know we have been successful if:

1. Staff have the appropriate skills and support to effectively care for patients at the end of their life with 25% of staff trained by April 2014 and 50% by July 2014.
2. Families speak positively about end of life care within the Trust, measured through the bereavement survey.
3. Patients are supported to return home more rapidly with paperwork completed within 48 hours and discharge achieved within 72 hours.
4. More people have advanced care plans in place which support them to die in their preferred place of care.

A summary of all the actions we are taking to improve patient flow is on the following page and the detailed actions are shown in Appendix 1.

Patient Flow Improvement Plan On A Page



Barking, Havering and Redbridge University Hospitals NHS Trust

unlocking our potential

section three – patient care and clinical governance

our improvement plan for 2014/15

3.1 Sepsis
3.2 Documentation
3.3 Quality governance
3.4 Patient experience

Improving the way we treat people with sepsis

Why this is important

Sepsis is a serious illness which is caused by severe infection and is sometimes called septicaemia, or blood poisoning. There are different stages of sepsis and as it becomes more severe it can be very dangerous. It is therefore important to recognise signs of sepsis, screen for sepsis and to rapidly give patients with sepsis or septic shock a defined set of treatment.

The CQC found that:

- Staff they spoke to had not been trained in BHRUT to recognise and manage sepsis, were not able to define what sepsis was and did not know if there was a guideline available to follow
- the Trust did not use a best practice tool such as the Sepsis Six which is a series of life saving interventions and that the observation charts did not prompt staff to consider sepsis.

Our assessment of the key issues:

The Trust has carried out an audit of a sample of around 80 patients who had sepsis to see whether the best-practice standards were achieved. The audit showed that improvements could be made in:
- the awareness of clinical staff about sepsis and the Sepsis Six care bundle
- the time between patients presenting to hospital and receiving antibiotics
- the consistent delivery of the 3 tests and 3 treatments (known as the Sepsis Six) to patients who are identified as having sepsis.

Our improvement objectives:

1. Improve the awareness and recognition of sepsis
2. improve the number of patients who have evidence based care to reduce mortality

Our priority actions that will deliver the biggest impact are:

Objective one: Improve the awareness and recognition of sepsis

1.1 Raise awareness of sepsis and deliver training for our clinical staff.

Objective two: Improve the number of patients who have evidence based care to reduce mortality

2.1 Implement a screening tool for sepsis and the Sepsis Six care bundle
2.2 audit our compliance with the College of Emergency Medicine standards for A&E, and the sepsis six care bundles, to ensure that our actions are effective.

We will know we have been successful if:

1. Sepsis is identified promptly through use of the sepsis screening tool
2. patients have the three investigations and three treatments (the Sepsis Six) within the first hour
3. mortality from Sepsis reduces.

Our detailed action plan is shown in Appendix 1.

Improving documentation

Why this is important

Good record keeping is an integral part of nursing, midwifery and medical practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow. Good record keeping, whether at an individual, team or organisational level, has many important functions including:

- Showing how decisions related to patient care were made
- helping to identify risks, and enabling early detection of complications
- promoting better communication and sharing of information between members of the multi-professional healthcare team and making continuity of care easier
- supporting effective clinical judgements and decisions
- providing documentary evidence of care and treatment provided.

The CQC found that:

- Many records, including discharge plans, are not consistently kept-up-to-date and do not include the care patients either need or have received
- documents did not include the more personal aspects of care, which can impact on experience and dignity
- patients are transferred across our sites without proper records.

Our assessment of the key issues:

The Trust has not placed sufficient emphasis historically on the importance of documentation and good record keeping; this is partly a result of a perception of insufficient time being available to front line staff.

Past audits have also identified concerns around the quality of documentation, however this has not been effectively addressed.

Our improvement objective is:

1. **To ensure that patients are being regularly reviewed and assessed, evidenced by complete documentation.**

Our priority actions that will have the biggest impact are:

1.1 Reinforce and communicate the standards required in respect of documentation
1.2 regularly review patient notes to ensure nursing documentation is of agreed standard
1.3 review all of our documentation to identify changes to streamline it and improve integration with other healthcare professional records.

We will know we have been successful if:

1. A minimum of 95% of records meet all the documentation standards by October 2014
2. 100% of patients transferred between sites have a completed checklist in place by April 2014.

Our detailed action plan is shown in Appendix 1.

Ensuring effective systems to monitor and improve quality of services

Why this is important

The NHS Constitution commits all NHS organisations to a series of values including a 'commitment to quality of care' which states:

"We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes."

Currently we are not able to consistently demonstrate that we have the systems, processes and culture in place to achieve this commitment.

The CQC found that:

- Incident reporting systems did make clear how the trust was learning from incidents and making necessary changes
- key safety and quality data is not aggregated into one place to allow for the recognition of themes
- there are not effective systems in place to monitor the quality of the services provided
- there was variation in how national guidelines (eg NICE) are being implemented and monitored
- some staff were unaware of the link between changes in practice as a result of learning from incidents.

Our assessment of the key issues:

The challenges we face are driven by a number of issues:

- Significant focus has been on responding to operational quality and safety challenges which has diverted attention away from developing systematic solutions
- high turnover of staff (including large number of temporary staff) leading to limited organisational memory and a need for significant ongoing induction and training of new staff in trust systems and processes
- limited organisational capacity and capability around clinical governance
- the Trust has not yet undertaken Quality Governance Assurance Framework (QGAF) in readiness for any future Foundation trust application.

Our improvement priorities are:

1. Improve our systems for overseeing quality of services and ensuring that care is effective
2. improve our risk management systems and processes
3. improve how lessons are learned and changes made.

Our priority actions that will have the biggest impact are:

Objective one – improve systems for ensuring care is effective

1.1 We will implement a standardised clinical governance infrastructure across all directorates and review the clinical governance self assessment and address any gaps
1.2 we will strengthen the corporate clinical governance department with staff who will be centrally managed but will work with directorates to provide expertise and support
1.3 we will expand the quality metrics that are monitored within the Trust through the implementation of board to ward reporting
1.4 we will implement a peer review process in which each directorate will have a peer review of quality and safety twice a year
1.5 we will review our compliance against all NICE guidelines and implement a new system for considering new guidance that is published.

Objective two – improving our risk management systems

2.1 We will put in place a dedicated risk manager and review all of the risk registers to ensure they are up to date.
2.2 we will incorporate a monthly review of risk registers into the strengthened clinical governance process
2.3 we will implement an audit programme of completed actions
2.4 we will strengthen the QIA process to include key metrics that will be tracked to ensure that potential risks are monitored as CIP schemes are implemented.

Objective three – improve how we learn and make changes

3.1 We will audit the action plans for all incidents which result in severe or moderate harm to ensure the actions taken have been effective
3.2 we will review the top three lessons learned from incidents, complaints and claims and run targeted campaigns to raise awareness and promote change on a quarterly basis.

We will know we have been successful if:

1. 100% of directorates have had an internal assurance review by November 2014
2. there is a standard clinical governance system in place across all Directorates
3. all wards have a ward quality dashboard within a 'ward to board' reporting framework
4. 100% of areas have an up to date and accurate risk register which is driving decision making and improvement actions to mitigate risk
5. staff report that they have confidence that if identifying risks, action will then be taken
6. the Trust is compliant with NICE guidance or has assessed and managed the risk where it is not
7. staff are aware of the lessons from incidents and there are clear records of improvements that have been made, and audits to show they are effective.

Improving patient experience

Why this is important

Patients have a right to be treated with compassion, dignity and respect within a clean, safe and well managed environment, a right which is enshrined in the NHS constitution.

We want our patients to not only be treated well clinically, but also in a way which makes them feel safe and cared for. We want people who use our services to speak positively about their experience, as an important marker of quality.

The CQC found that:

- Many patients and relatives were complementary about the care they received and the way staff spoke with them
- more work is required to ensure the improvements are reflected in future national inpatient surveys.

Our assessment of the key issues:

- As a result of the challenges that the Trust has faced it does not have a strong reputation within the local community and has not been able to address this in recent years. We need to use the experience of other Trusts who have improved their patients experience to address this issue
- although the results of the Friends and Family Test have improved, these results have not been reflected in the national surveys. We think that this is partly because the surveys cover patients who were treated some time ago, and partly because the underlying reputation of the Trust has an influence on how people respond to the national surveys.

Our improvement objectives are:

1. To improve the reported level of satisfaction with the services we provide by responding to patient feedback
2. ro positively improve the reputation of the services amongst the local population

Our priority actions that will deliver the biggest impact are:

Objective one – to improve the reported level of satisfaction by responding to feedback

1.1 We will increase our reporting of the Friends and Family Test to weekly, and will broaden the scope to include outpatients
1.2 we will implement a programme of non-executive director visits to departments
1.3 patient stories will be the first item on the Board agenda
1.4 we will work with other Trusts to learn from other Trusts who have improved their patients experience, as measured by the national surveys, and incorporate their learning into our actions.

Objective two – to positively promote the Trust to improve the reputation of its services

2.1 We will introduce a ‘you said we did’ campaign on a monthly basis with proactive communication inside and outside the Trust
2.2 we will commission an independent assessment of the views of key opinion formers about the quality of services and develop a plan to address any areas of weakness

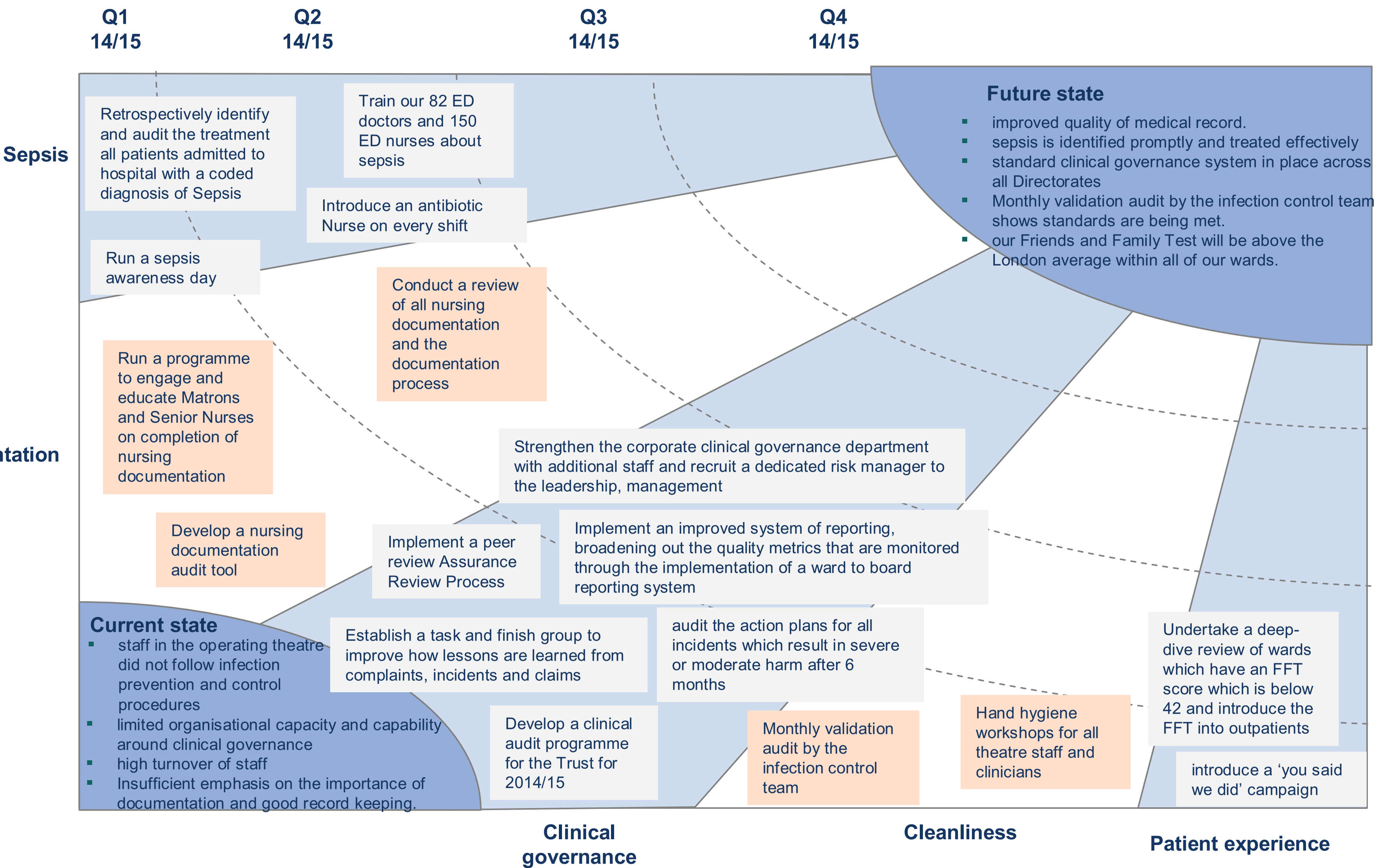
2.3 we will improve the way in which we promote positive news about the Trust to the local community.

We will know we have been successful if:

1. Our in-patient Friends and Family Test is consistently above the London average within all of our wards.
2. our ED Friends and Family Test is answered by 20% of patients and improves from its current position to the London average or better
3. 0ur 'you said, we did' campaign can evidence on a monthly basis our reaction to patient's experiences.

A summary of all the actions we are taking to improve clinical governance and patient experience is shown on the following page and the detailed action plans are shown in Appendix 1.

Patient care and clinical governance improvement plan on a page



Barking, Havering and Redbridge University Hospitals NHS Trust

unlocking our potential

section four – outpatients

our improvement plan for 2014/15

4.1 Outpatients
4.2 Day care surgery

Improving our outpatient services

Why this is important

There are 670,000 outpatient appointments at our hospitals each year. Many people therefore rely on us to provide them with a high quality service in which they are seen promptly, at a time convenient to them and by the right doctor.

The CQC found that:

- Appointments are not being booked properly, with poor communication to patients about the time, date and venue of their appointment leading to confusion, and patients not being booked to see the right doctor for their condition
- scheduled appointments are delayed or cancelled for a number of reasons including missing notes, consultants being double booked and staff arriving late
- the environment in which the sexual health service was located was not fit for purpose.

Our assessment of the key issues:

Since the CQC report we have undertaken an initial review of our outpatient service. It is clear that major improvements are needed. There are a number of issues that have been unresolved for some time, and these have been further exacerbated by the introduction of our new PAS system, although this will help us improve our service once fully implemented.

We have found that:

- Patients are not being booked into the correct clinics because our directory of services is out of date, and our consultants are not reviewing referrals quickly enough to make sure patients are seen in the right clinic
- patients are not able to get through to the contact centre if they want to make or change an appointment
- our staff are not tracking medical records when they are moved between departments which means we are unable to easily locate the notes to make sure they are available for the appointment. We found that approximately 15 – 20% of notes are missing based on a snapshot audit that we completed over a two week period
- our clinic schedules need to be completely reviewed and changed because we are booking too many patients at the same time and at short notice
- we are cancelling appointments because of poor coordination with doctors annual leave and are not able to re-arrange the appointments in a reasonable timeframe
- our IT systems for communicating appointments or changes is ineffective and means patients receive multiple letters and have delays in getting appointment confirmed
- systems were not used to check the impact on service quality of moving our sexual health clinic.

Our improvement objectives are:

1. To improve the environment of the sexual health clinic
2. to re-build all of our clinic appointment slots so that patients are seen on time in the right clinic
3. to improve the information we collect about how effective the outpatient service is, monitoring it more closely and taking prompt action where improvements are needed.
4. to improve our administrative and customer service arrangements.

Our priority actions which will have the greatest impact are:

Objective one – restructure our outpatient clinic slots

2.1 We will re-profile all the clinics that we run to create the right number of slots at the right time intervals and will make sure that clinics are only scheduled when doctors are available
2.2 we will rebuild the directory of services so patients are referred to the correct clinics
2.3 we will leave some clinics vacant so that if we need to rearrange an appointment a patient does not wait too long for a new appointment
2.4 we will ensure that clinicians are job planned in a way that enables them to attend clinic on time.

Objective two– improve the information we use to oversee, monitor and improve the effectiveness of our outpatient service

3.1 We will introduce weekly monitoring and then we implement the functionality of the new PAS system which will enable us to have better information to monitor the services
3.2 we will introduce the Friends and Family Test into outpatients and report by consultant
3.3 we will implement regular senior manager visits to outpatients to seek feedback from patients and staff.

Objective three – improve our administrative and customer service arrangements

4.1 We will review and monitor the printing workflows to ensure they are correctly set up
4.2 we will create a dedicated team of staff who are focused solely on call handling
4.3 we will ensure that the improvement actions are joined up with the work which is taking place to ensure our newly implemented computer system is fit for purpose.

We will know if we have been successful if:

1. Patients are seen in appropriate environments and speak positively about their experience
2. 80% of patients are seen within 15 minutes of their appointment time
3. their medical records are available to the doctor or specialist nurse who is seeing the patient
4. patients are seen by the right clinician in the right clinic first time
5. appointments are not rescheduled un-necessarily
6. the average 'did not attend (DNA) rate drops from 12% to 10% in the first six months from implementation
7. the DNA rate is sustained for a period of three months thereafter and shows a declining trend.

A summary of the actions we are taking is shown at the end of this section and our detailed action plan is shown in Appendix 1.

Day care surgery

Why this is important

Each year, over 65,000 patients have day surgery across our two hospital sites. The CQC found that too many of our operations are cancelled and too often patients have to recover from their operation in areas which do not provide a good experience.

The CQC found that:

- Patients recovery after day surgery was not properly managed in order to provide a good experience
- too many operations were cancelled, with some being cancelled two or three times.

Our assessment of the key issues:

- Day surgery environment means patients often undergo recovery in the wrong environment
- poor processes and lack of escalation and oversight leads to too many cancelled operations.

Our improvement objectives are:

1. To improve the environment in recovery as a short term measure
2. reduce the number of patients whose operation is cancelled
3. improve the arrangements for patients after they go home if they have any concerns or queries

Our priority actions which will have the greatest impact are:

Objective one – improve the environment

1.1 We will create toilet and shower facilities and ensure that a nurse is specifically identified to care for patients who stay in recovery

1.2 our improvements in patient flow should mean that in the medium term patients will be able to move to a ward more quickly, and in the longer term we are creating a dedicated elective centre at King George Hospital, separated from the emergency care pathway.

Objective two – reduce the number of cancelled operations

2.1 We will introduce additional flexible lists on demand to provide additional capacity for urgent cases so that routine surgery is not cancelled.

Objective three – improve our aftercare for patients

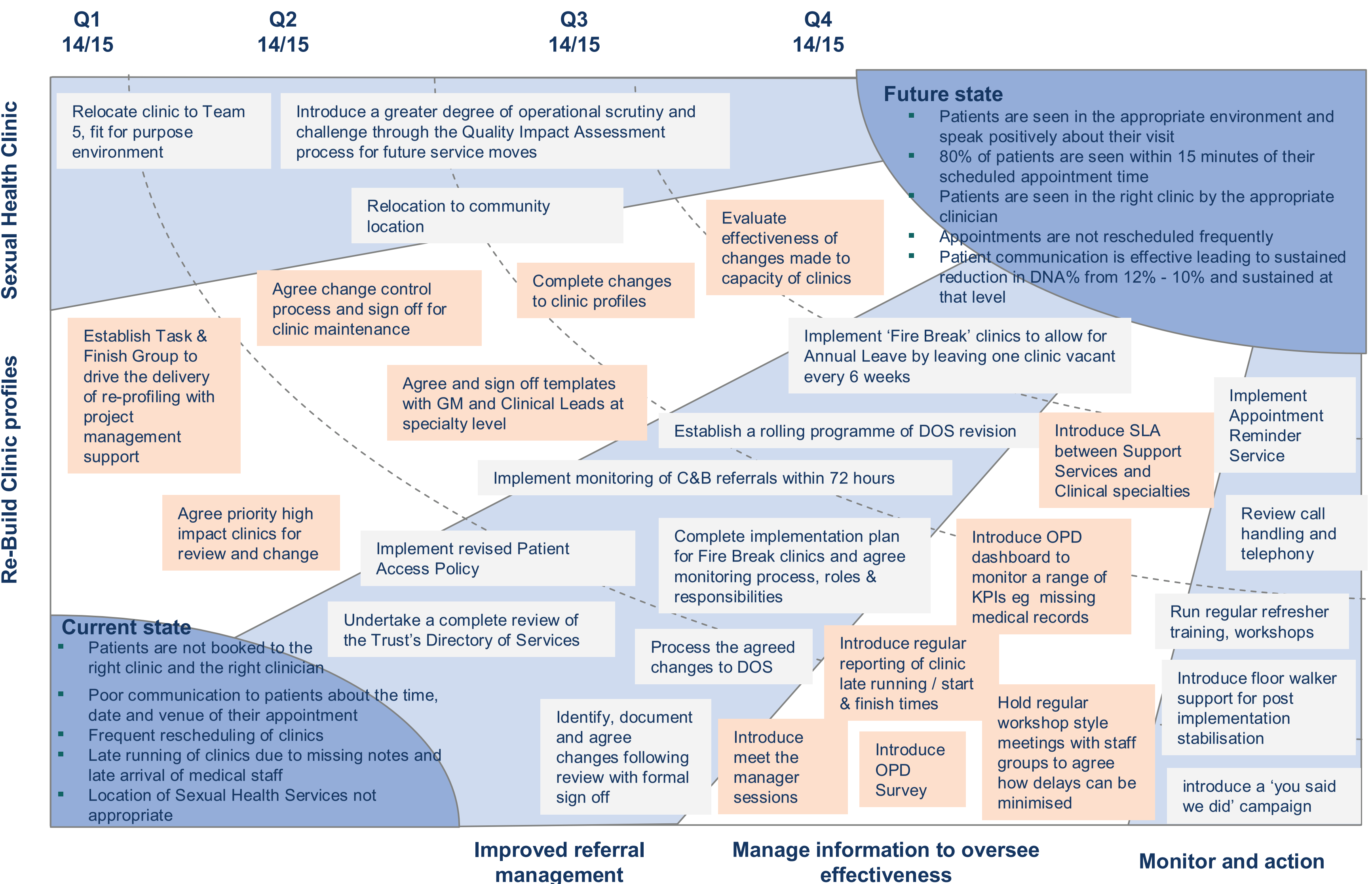
3.1 We will provide patients with be given a dedicated contact number to call if they are experiencing any pain or have post-operative queries.

We will know we have been successful if:

1. The patient's experience of day surgery is improved through the availability of toilet and shower facilities. The provision of cold food during the day will improve the environment for patients recovering from anaesthetic.

2. the number of cancellations for day surgery procedures is reduced. In particular the number of patients experiencing cancellation for a second or third time will be significantly decreased through the improved use of flexible capacity
3. patients report greater satisfaction with their day case surgery and the support they receive after going home.

Outpatient Improvement and re-design



Barking, Havering and Redbridge University Hospitals NHS Trust

unlocking our potential

section five – leadership and organisational development

our improvement plan for 2014/15

Leadership and organisational development

The Trust was placed in special measures because of the scale of the improvements that needed to be made.

A new Chief Executive takes up post in April 2014 and the Trust will also receive feedback from the capability review that was undertaken.

As such, the improvement objectives associated with leadership,management and organisational development will be agreed once the new Chief Executive starts in post.

The priorities for development are likely to include:

1. Developing a clear, concise strategy for the Trust
2. Stabilising the senior leadership team and developing a strengthened unitary board and executive team
3. Ensuring there is an effective structure and operating model in place to support effective execution and delivery
4. Ensuring the executive team have appropriate portfolios to support aligned and effective delivery
5. Ensuring there is adequate capacity in the non-executive director team, and strengthen the arrangements for holding the executive to account
6. Strengthening clinical leadership, and strengthening the collective medical, nursing and managerial leadership arrangements at a service level
7. Improving the responsibility for external relationships and developing better and stronger partnerships
8. Improving the management and clinical information within the Trust, and how it is used to become a more data driven organisation with better board to ward reporting
9. Improving the focus on follow through, follow up and supporting development whilst strengthening holding people to account
10. Strengthening the communications function
11. Improving our staff and partner engagement

Barking, Havering and Redbridge University Hospitals NHS Trust

unlocking our potential

section six – delivering the improvement plan

our improvement plan for 2014/15

Delivering improvement: Introduction

We recognise that in the past we have developed detailed plans that have not been fully implemented, and that delivery of the scale of change that is required is a risk to the achievement of our improvement objectives.

Approach

The Trust has identified an executive director, who supported by the TDA Improvement Director will oversee the implementation of the changes we have identified. We will appoint a dedicated programme director and a clinician to lead the implementation.

The delivery of change will be integrated into our 'business as usual' arrangements because it is important that improvement becomes a more structured part of our day to day work. However, we recognise that additional dedicated resource embedded within our business as usual arrangements will be required to achieve the level of change we have identified.

Where improvement work identified in the plan can be integrated with or drive delivery of existing programmes of work, such as that of the integrated care coalition on frailty and long term conditions we will do so.

Each of our key improvement themes is led by an Executive Director who acts as SRO, and will be supported by additional dedicated project management resource embedded within the directorates, but managed by the central programme director and a project management office which will monitor delivery.

Recognising that the success of other organisations and BHRT are interdependent in many ways, the Trust will identify the most effective way of securing the additional implementation support in partnership with local stakeholders, and will ensure that this is used to build capacity and capability in change and improvement within the Trust's operational and clinical staff.

Resource implications

There are four types of resource required to effectively implement the changes we have identified:

1. Additional recurrent expenditure in the short term, which should lead to efficiencies in future years
2. Non-recurrent expenditure to support the implementation of the plan through additional clinical and management capacity, PMO support and additional external expertise
3. Transitional expenditure in which additional capacity may be required to provide stability and headroom whilst the changes are implemented
4. Additional capacity in out of hospital settings

Support from partners

The Trust has been well supported by partner organisations during the development of the improvement plan, for which we are very grateful. The improvement plan contains changes that can only be implemented with support from partners and these are summarised below.

Workforce:

1. Positively promoting the Trust and the local area as a great place to live, train and work
2. Creating workforce rotations that maximise the fill rate of doctors in training – in particular in medical specialities and emergency care
3. Support the creation of joint consultant posts, or rotational posts.
4. Supporting the development of Queen's Hospital as a site for future training programmes

Patient flow:

1. Implementing advanced care planning to prevent people needing emergency care
2. Piloting the deployment of specialist assessment in peoples homes as a response to some calls to the ambulance service
3. Streamlining the paperwork requirements to support discharge (such as CHC and fasttrack)
4. Broaden the criteria for intermediate care beds and implement a trusted assessor model
5. Implement the discharge to assess model
6. Implement the evidence based interventions to reduce readmissions to hospital
7. Increase the support of CTT and IRS to 'pull' patients out of sub-acute hospital beds

Leadership and organisational development:

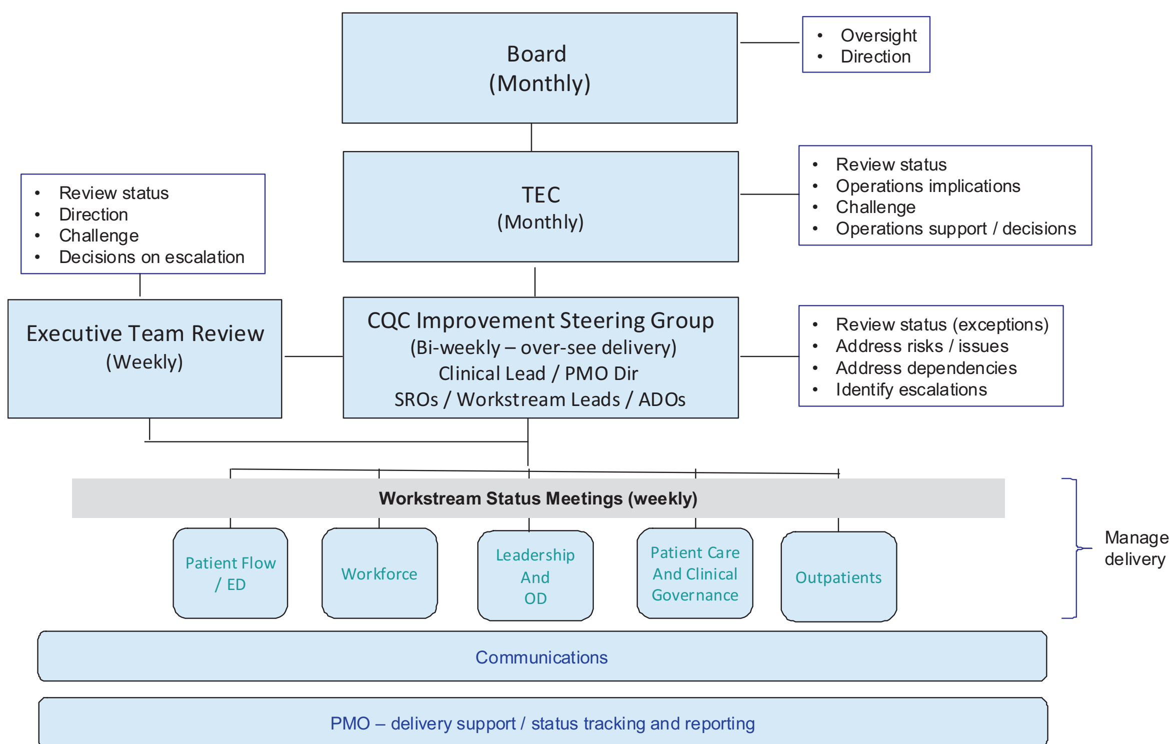
1. Supporting the positive promotion of the Trust and its services where appropriate
2. Implementing joint leadership and development programmes for clinicians and managers across health and social care
3. Supporting the development of stronger and more effective joint working arrangements
4. Supporting the development of an outward facing organisation and bringing an external view inside the Trust

Key risks to delivery

1. Capacity and capability within BHRT is inadequate to implement and embed the changes identified
2. There is insufficient focus on the delivery of the changes required due to competing priorities
3. The changes required cannot be effectively implemented because there is insufficient capacity to provide adequate stability in the emergency pathway from which change can be made
4. The Trust is unable to recruit to key clinical and managerial posts that are required to achieve the improvements
5. The support from partner organisations is insufficient to achieve the changes identified
6. The agreements reached at a senior level in organisations does not translate effectively into new ways of working at the shop-floor clinical interface.

Governance arrangements

The internal governance arrangements are summarised below



The delivery of the improvement plan will be overseen by the Board of Directors on a monthly basis, and two key sub-committees of the Board (Workforce Committee and Safety and Quality Committee) will provide further in-depth scrutiny and hold the Executive Team to account for delivery.

As has been described the improvement plan requires health economy oversight, particularly in relation to the emergency care pathway, and the Integrated Care Coalition will ensure collective delivery across all member organisations.

Conclusion – beyond the improvement plan

The improvement plan represents the start of a journey of improvement, putting in place the building blocks that will create the foundation for future change and improvement. It aims to stabilise the Trust, whilst taking the first steps to change the clinical, operational and governance models.

More strategic and transformational change can and will then follow on from this, allowing the Trust to take further steps with partner organisations to further transform services.

This is particularly the case for the emergency pathway in which the improvement objectives in this plan are aligned with delivery of a smaller emergency care workload and the acute reconfiguration which will consolidate acute services onto a single site.

A smaller, more efficient and more effective set of services, concentrated in fewer areas will support the Trust and the health economy move towards the goal of clinically excellent and financially sustainable services delivering care for local people in the right setting.

1. There will be a lower workforce requirement, which will mean that the Trust will be able to operate with a lower core staff base. This will improve quality as currently the Trust relies on high levels of expensive temporary staffing to run the current number of wards that are required.

2. Acute care will be concentrated on the Queen's Hospital site, allowing the release of acute estate at King George Hospital to be developed for step down and then ambulatory care as the full impact of the shift to home based care is achieved.

3. The senior medical workforce will be concentrated on a single site (for emergency care) allowing quality standards to be achieved.

This improvement plan therefore sets the stage for future and ongoing improvement and transformation of services for our local community towards the local health economies vision.

Barking, Havering & Redbridge University Hospitals NHS Trust
March 2014

Item 9

REPORT

Joint Health Overview and Scrutiny Committee

22 July 2014

Subject Heading:	Committee's Work Programme
Report Author and contact details:	Anthony Clements, London Borough of Havering Tel: 01708 433065 Anthony.clements@onesource.co.uk
Policy context:	To agree the Committee's work programme for the 2014/15 municipal year.
Financial summary:	The work of the Joint Overview and Scrutiny Committee will be covered by the previously agreed charging scheme between the boroughs.

SUMMARY

At this stage of the municipal year the Committee needs, so far as is practicable, to agree its work programme for the forthcoming year. This applies to both the work plan for the Committee as a whole and to the subject of any panel or topic group run under the Committee's auspices.

RECOMMENDATIONS

1. That the Committee agree its work programme for the 2014/15 municipal year.
2. That the Committee agree a draft programme of visits that it wishes to undertake during 2014/15.

REPORT DETAIL

2.1 Shown in appendix 1 is a draft work programme for the Committee's remaining meetings during the municipal year. This has been drawn up by officers following initial discussions with the borough health scrutiny Chairmen.

2.2 Members will be aware that the agenda for this (first) meeting of the Joint Committee includes presentations from BHRUT and by the Commissioning Support Unit on the cancer and cardiovascular service change proposals and Members may wish to add items to the work programme in light of the input from these officers. The work programme also accommodates an annual update from Moorfields Eye Hospital NHS Foundation Trust as this was a recommendation of the group of Committee Members who visited the hospital earlier this year.

2.3 Members will note that a significant proportion of the workplan has been left blank at this stage. This is to reflect the fact that Members may well wish to select further issues for scrutiny in light of the briefings they are given by Health Trust officers during the year. In addition, previous experience has shown that it is beneficial to leave some excess capacity for scrutiny in order to allow the Committee to respond fully to any consultations or other urgent issues that may arise during the year.

2.4 Additionally, the Committee has the power to select an issue for more in depth scrutiny as part of a scrutiny panel or topic group review. It is recommended that, in view of limited resources, only one such topic group is run at any one time. The Committee is therefore requested to consider at this stage, again with the support of officers, if it wishes to undertake a topic group review and what its subject should be.

2.5 The Committee has previously found visits to sites of health services covering two or more of the constituent boroughs to be an extremely effective way of scrutinising services as they actually operate 'on the ground'. The Committee is also therefore asked to consider what, if any site visits it wishes to undertake during the municipal year.

2.6 It should be noted that the Committee also has the power to request written information from local Health bodies on any subjects within its remit. This power can continue to be used by the Committee at any time and is not therefore considered within this report.

IMPLICATIONS AND RISKS

Financial implications and risks:

None – it is anticipated that the work of the Committee will continue to be funded via the existing charging scheme between the Councils.

Legal implications and risks:

None.

Human Resources implications and risks:

None.

Equalities implications and risks:

None although one outcome of effective health scrutiny will be to reduce health inequalities for Outer North East London residents.

BACKGROUND PAPERS

None.

Appendix 1: Draft Work Programme for Joint Overview and Scrutiny Committee

14/10/2014 Havering	**13/01/15 Redbridge**	**14/04/15 Waltham Forest**
GP contract arrangements and list sizes.	Essex pharmacy arrangements with GPs	
CCGs – Prime Minister's challenge fund work	Moorfields update	
NELFT update	Maternity services	

Havering
LONDON BOROUGH

Essex County Council

Item 10
REPORT

Joint Health Overview and Scrutiny Committee

22 July 2014

Subject Heading:	Role of Local Healthwatch (LHW) with the Joint Health Overview and Scrutiny Committee
Report Author and contact details:	Anthony Clements, London Borough of Havering Tel: 01708 433065 Anthony.clements@onesource.co.uk
Policy context:	To decide if representatives of Local Healthwatch organisations in Outer North East London should continue as non-voting co-opted members on the Committee.
Financial summary:	There are no apparent financial implications of the Committee's decision on the role of Local Healthwatch representatives.

SUMMARY

This report asks the Committee to consider whether the existing arrangements for the co-option of representatives of the Local Healthwatch organisations should continue in the new Council term.

RECOMMENDATIONS

1. That the Committee decide whether or not to allow one co-opted, non-voting member from each of the following Healthwatch organisations:

   Healthwatch Barking & Dagenham
   Healthwatch Havering
   Healthwatch Redbridge
   Healthwatch Waltham Forest

REPORT DETAIL

1.1 Members will be aware that Local Healthwatch organisations (LHW) play an important role in seeking to review and improve services in both health and social care. Overview and Scrutiny Committees also have a statutory duty to consider matters referred to them by LHWs.

1.2 For the past four years, a representative from each of the four LHWs (or predecessor bodies) covering the Outer North East London boroughs has been co-opted onto the Committee. The four Healthwatch representatives do not have voting rights but are given the same rights to ask questions of witnesses and are otherwise treated as full members of the committee. At the start of a new Council term, Members are invited to consider whether they wish to continue with the present arrangements in this regard.

1.3 It should be noted that, regardless of the decision on Healthwatch co-optees, meetings of the Joint Committee are normally held in public and it therefore remains open to any Healthwatch member to attend any meeting. At the discretion of the Chairman, Healthwatch attendees, as well as other members of the public, will also retain the opportunity to ask questions of witnesses giving evidence or to address the Committee.

IMPLICATIONS AND RISKS

Financial implications and risks:

None.

Legal implications and risks:

Although the Joint Committee is required to consider matters referred to it by Healthwatch, it has no statutory obligation to co-opt any Healthwatch members onto the Committee.

Human Resources implications and risks:

None.

Equalities implications and risks:

None.

BACKGROUND PAPERS

None.

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