

**MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Waltham Forest Town Hall
14 April 2015 (2.00 – 5.05 pm)**

Present:

Barking & Dagenham

Councillor Eileen Keller

Havering

Councillor June

Alexander (substituting
for Councillor Nic Dodin)

Councillor Gillian Ford

Redbridge

Councillor Stuart

Bellwood

Councillor Mark Santos

Councillor Tom Sharpe

Waltham Forest

Councillor Gerry Lyons

(substituting for
Councillor Stuart
Emmerson)

Councillor Richard

Sweden (Chairman)

Essex

Councillor Chris Pond

Co-opted Members present:

Alli Anthony, Healthwatch Waltham Forest

Ian Buckmaster, Healthwatch Havering

Mike New, Healthwatch Redbridge

Manisha Modhvadia, Healthwatch Waltham Forest

Also present:

Councillors Kastriot Berberi and Yemi Osho, Waltham Forest

Health officers present:

Peter Morris, Chief Executive, Barts Health

Jo Carter, Barts Health Communications

Lynne Hill-Tout, Interim Managing Director, Whipps Cross Hospital

Deborah Kelly, Barts Health

Mike Roberts, Barts Health

Dr Steve Ryan, Chief Medical Officer, Barts Health

Lucy Hamer, Care Quality Commission
Hatley Marle, Care Quality Commission

Alan Steward, Chief Operating Officer, Havering CCG
Ilse Mogensen, North East London Commissioning Support Unit

Council officers present:

Masuma Ahmed, Barking & Dagenham
Bill Brittain, Group Manager, Intensive Support, Barking & Dagenham
Anthony Clements, Havering (clerk to the Joint Committee)
Jilly Szymanski, Redbridge
Dan Fryd, Waltham Forest
James Holden, Waltham Forest
John Savage, Waltham Forest
Ramzi Suleiman, Waltham Forest

Approximately 15 members of the public were also present.

All decisions were taken with no votes against.

35 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of arrangements to be followed in case of fire or other event requiring the evacuation of the meeting room or building.

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

Apologies were received from the following Councillors:

Barking & Dagenham:
Sanchia Alasia
Danielle Lawrence

Havering:
Nic Dodin (Councillor June Alexander substituting)
Dilip Patel

Waltham Forest:
Stuart Emmerson (Councillor Gerry Lyons substituting)

37 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of pecuniary interest.

38 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 13 January 2015 were agreed as a correct record and signed by the Chairman.

39 BARTS HEALTH - RESPONSE TO WHIPPS CROSS HOSPITAL CQC INSPECTION

The Barts Health NHS Trust chief executive explained that an inspection of Whipps Cross Hospital by the Care Quality Commission (CQC) had taken place in November 2014 and had revealed significant concerns in a number of areas including A&E patient flow, staffing and bullying. Following the inspection, a risk summit was organised with stakeholders in March 2015 and Barts Health wished to be inclusive with other organisations as part of its improvement plan.

Significant concerns raised by the CQC included issues of staffing, morale & culture, the routine delivery of standards such as keeping to timetables for treatment and the lack of safety policies and embedding of safety etc. The Trust management believed that the public would still get good outcomes and care at Whipps Cross but accepted that patients had been let down. While there were good aspects of care at Whipps Cross, improvements were also required.

The Trust Medical Director explained that immediate recovery action was agreed with the Trust Development Agency, local Clinical Commissioning Group (CCGs) and Healthwatch Waltham Forest. Significant progress had been made around improving the quality and safety of clinical care. Daily meetings were held where nurses could share any concerns around patient care. The number of medical patients treated on surgical wards had been reduced and the seven-day site presence of senior management had also been improved.

As regards staffing levels, improvements had been made but there was still a reliance on use of agency staff on some wards. The budgeting process for the nursing establishment was currently in progress and the Trust aimed to reduce its need for agency staff. On safeguarding, the introduction of a babytracking system at Whipps Cross maternity had not been concluded and the Trust accepted that this needed to be actioned. Recruitment had taken place to the senior leadership team whose visibility had improved, making it easier for staff to escalate issues if necessary.

The Trust and hospital leadership were keen that staff understood and engaged with the hospital improvement plan. On outpatient issues, the Trust wished to meet waiting time targets, avoid duplication of appointment letters and ensure patient records were available at appointments. In A & E, the objectives were to ensure patients were seen and assessed promptly, admitted to the correct ward and discharged safely.

Trust officers felt that recruitment had improved with the ratio of permanent, agency and bank staff being looked at. A new eight-bed High Dependency Unit was due to open at Whipps Cross by December. It was accepted that communication around the hospital improvement plan had to be improved both with stakeholders and the general public and also with the hospital's own staff.

It was also important that staff were engaged in delivering better care and a clinical senate had been established to manage the hospital at a local level. A quality and safety committee would also be set up to allow safety issues and complaints to be dealt with on site at Whipps Cross.

The final area of the hospital improvement plan covered compassion in care – an area of good practice referenced in the CQC report. A compassion in practice working group dealt with key areas of concern such as care of the elderly and dementia. It was aimed to make the hospital estate more dementia friendly. End of life care – an area criticised in the CQC report was also being worked on. Work was being undertaken with the Patients Association and the hospital was keen to work with both local and national patient groups.

Questions and discussion

The Trust chief executive agreed that the raising of concerns by staff should be encouraged and felt that it was people's duty to do this. Staff would not be penalised for raising concerns and the Trust had a private means for staff to raise concerns about issues such as bullying. This had been reinforced in the values of the organisation and 1,500 staff leaders were being trained in the Trust's values.

The hospital areas with the highest amount of reliance on agency staff were children's in-patients wards, surgical wards and A & E. Whipps Cross now had a full complement of ED consultants but struggled to recruit ED nurses. The recruitment situation on the children's wards had improved recently although there remained large numbers of new staff in this area.

The new leadership at Whipps Cross did have the authority to tackle problems at the hospital. The post of managing director at the hospital was currently on an interim basis but would be advertised permanently in due course. This would allow a higher level voice to represent Whipps Cross to the Trust Board.

Recruitment in paediatrics was a national issue. Specialist recruitment agencies and incentive packages were therefore employed to aid recruitment to these areas at Whipps Cross. It was hoped to reach almost full establishment for children's staffing at Whipps Cross by the end of March. Elderly wards were now almost at full establishment and the new staff were of high calibre and enjoying working at Whipps Cross. Recruitment difficulties for surgical wards were also seen in other areas rather than just Whipps Cross. The Trust wished to use their own staff bank

to fill vacancies rather than external temporary staff. Other incentives to attract staff being considered included rotation across sites, clear career pathways and education & training opportunities.

The private finance initiative (PFI) did not impact on the quality of care at Whipps Cross. The PFI cost did total £28-30 million and the Trust wished to address the long-term issues around this. The estate at Barts and the Royal London hospitals was in a good condition. The remainder of the Trust's estate required an upgrade however and there was a maintenance backlog across the Trust of approximately £80 million. Around £16 million had been invested in the estate in 2014/15 although much of this investment was not visible to the public. The four oldest operating theatres at Whipps Cross were being replaced at a cost of £9.2 million.

The communications strategy around Whipps Cross would include the local press and local residents. The Trust wished to improve patients' experiences and then make these improvements clear to the wider public. It was suggested that the annual Barts Health awards could be hosted at a venue closer to Whipps Cross in order to boost the profile of the hospital.

Hospital management accepted that most media stories about Whipps Cross (both positive and negative) were true but there were also some areas of very good practice at the hospital. These included endoscopy and the new heart service at the hospital. The induction of labour had been improved at Whipps Cross maternity and this had been praised in the CQC report.

The Trust respected equal pay obligations and the requirements of safe staffing. London weighting issues were also taken into account. As regards falls prevention and frailty of patients, the Trust was prioritising this and wished to adopt national best practice on frailty. More senior geriatricians needed to be employed by the Trust and more weekend working would be introduced in order to develop the elderly pathway. A falls strategy had been operating at the Trust for the last two years and all wards were required to report incidents of patient falls. The number of falls across the Trust as a whole had been reduced but further improvement was needed.

The Trust wished to extend the opening hours of its Patient Advice and Liaison Service (PALS) in order that the service was available out of hours. Recruitment to a more dynamic PALS model was currently under way.

As regards end of life care, a compassionate care plan for the dying had been produced but its implementation had been delayed. Staff training on this policy was expected to start shortly. It was accepted that more work needed to be done at the Trust on end of life care. The Trust was not aware of any issues around screening programmes being raised by the CQC.

The Trust chief executive felt that Barts Health did have a fully committed and dynamic management team. A new Trust Chairman was due to be appointed in early June and further senior appointments would follow.

A lot of partnership working was included in the improvement plan and the overall nursing strategy and care model. Regular use was made of national networks such as the Health Education Network. The robustness of patient panels at Barts Health needed to improve and the Trust also wished panels to be more representative of their local communities with e.g. better youth representation. The Trust had obtained funding in order to develop this work.

Further details would be supplied of the Trust's work with people with dementia. A Member felt that the needs of people with dementia should be considered in all areas of the hospital and had established that this had not been done in the design of the new heart hospital at Barts. It was noted that there was a Trust-wide dementia strategy group in operation.

It was **AGREED** that progress at Whipps Cross be considered again by the Joint Committee in approximately six months and that in the meantime, a site visit should be arranged for Members in order to gain more of an understanding of the challenges and issues facing the hospital. The outcomes of the current Waltham Forest scrutiny review of end of life care would also be shared with the Joint Committee.

It was further **AGREED** that it be established with the Joint Health Overview and Scrutiny Committee for Inner North East London what scrutiny that committee was undertaking of the issues at Whipps Cross. It was noted that scrutiny of the Whipps Cross improvement plan was already being conducted by Waltham Forest, Redbridge and Essex health scrutiny committees. Any relevant outcomes from this work could also be brought back to the Joint Committee.

40 **CARE QUALITY COMMISSION HOSPITAL INSPECTION PROCESS**

Officers from the Care Quality Commission (CQC) explained that the CQC strategy committed the organisation to working closely with scrutiny. The CQC wished to strengthen this relationship further following issues such as those raised by the Francis Report. The CQC had recently produced a new guide for scrutiny committees on working with it. The CQC teams that inspected facilities for health, social care and primary & integrated care each wished to strengthen their relationships with scrutiny.

A new set of CQC standards for care had been introduced with effect from 1 April 2015. If the CQC found that services provided were not good, it needed to decide if the services provided required improvement or if they should be rated as inadequate. Services were also now required to put their

CQC rating on public display. Guidance for providers had now been updated and was available on the CQC website.

It was noted that the CQC was responsible for inspecting hospitals, GPs, dentists, mental health facilities, care homes, home care services, children's care facilities and healthcare within the criminal justice system.

Officers reiterated that the relationship with scrutiny was important to the CQC. The CQC inspection schedule was announced to scrutiny and a representative of the most local scrutiny committee was invited to the quality summit arranged by the CQC following an inspection. Inspection reports were also notified to scrutiny.

The CQC inspection of Whipps Cross had been undertaken in direct response to concerns raised by local stakeholders. Evidence was collected from stakeholders before each inspection and a team of 45 people had been involved in the inspection at Whipps Cross.

Inspections of Newham and the Royal London Hospitals had been undertaken in January 2015 and these reports were currently with the respective Trusts who were allowed to check matters of factual accuracy. The inspection at BHRUT had been dealt with supportively by the Trust and the report on this was due to be compiled by the end of April.

The CQC had the remit to look at how integrated services were and information was shared between the different sector CQC teams. The CQC also undertook thematic reviews looking at for example care and services for older people.

Members expressed disappointment at the lack of an invitation to Redbridge to the quality summit re Whipps Cross and the CQC officers accepted that it was important to identify correctly which overview and scrutiny sub-committee should be invited. This was also a challenge where hospitals treated patients from across several different Local Authority areas. Members also recorded their thanks to the CQC for an excellent report on Whipps Cross.

A member of the public asked why the CQC had not picked up concerns about Whipps Cross at an earlier stage. Officers responded that the CQC did have a database of evidence on Whipps Cross. Barts Health had been inspected in December 2013 by a team of 90. When it became clear that action plans were not being worked towards, the CQC announced a new inspection in November 2014.

A new power granted to the CQC was the authority to review end of life care. The CQC could also look at if there were clear responsibilities for care planning and further information could be provided on this.

The Committee **NOTED** the presentation from the CQC.

41 **CCG/NHS ENGLAND CO-COMMISSIONING**

The chief operating officer of Havering Clinical Commissioning Group (CCG) explained that NHS England wished for the commissioning of GP practices to be decided at a more local level. All four CCGs in ONEL wished to have full delegation in this area as this would allow the CCGs to drive integrated care. Delegation would relate to CCGs commissioning GP practices, performance managing practices as a whole and being involved when deciding on closures of practices.

It was hoped that delegation would allow improved care by GPs for people with long-term conditions. It was accepted that there were also risks to delegation such as to the reputation of CCGs as well as a potential conflict of interest as GP practices were themselves members of CCGs.

The CCGs were currently consulting their members on this issue. Full delegated commissioning responsibility had been approved for the four ONEL CCGs with effect from 1 April 2015. Governance arrangements were currently being considered and a primary care committee was being established to take on these responsibilities. The local Healthwatch organisations, Health and Wellbeing Boards and Councils would be non-voting members of the committee, which would meet in public. There would also be a wider reference group including BHRUT and other providers.

It was planned that the primary care committee would be established over the next two months and an update could be given to a future meeting of the Joint Committee. The position would be checked as regards whether non-voting members would be able to remain present during confidential part 2 discussions at the primary care committee.

The Joint Committee **AGREED** to recommend that non-voting members of the primary care committee should be present at discussions regarding the distribution of resources.

The CCG officer accepted that GP recruitment and retirement was a major issue and felt that workforce issues would be a key work stream of the primary care improvement programme. NHS England would continue to performance manage individual clinicians but the CCGs would undertake wider performance management on issues such as access to GPs. Funding received in Barking & Dagenham, Havering and Redbridge from the Prime Minister's Challenge Fund had been used to establish GP access hubs.

The Committee **NOTED** the position.

42 **URGENT CARE REPROCUREMENT**

The Committee was addressed briefly by a Waltham Forest resident and member of the Waltham Forest CCG steering group. The member of the public noted that the urgent care procurement process was now paused but felt there had not been sufficient involvement of patients and the public in the process. If there was to be a single provider of services such as NHS 111 and the out of hours GP service across the four boroughs, the member of the public wished to establish how the different demographics of the four boroughs would be taken into account and also what risk assessment had been undertaken.

The Havering CCG chief operating officer, on behalf of the four ONEL CCGs explained that the original competitive dialogue evaluation had left only one viable provider and the CCGs had therefore decided not to continue with that process. It was accepted that patient and public involvement could have been better and the new procurement process would commence with an urgent care conference in June 2015. This would involve the Joint Committee, Healthwatch, local Health and Wellbeing Boards as well as other stakeholders. The conference would aim to develop a high level specification for an urgent care pathway.

The CCGs wished to generate more interest in the urgent care procurement from a range of different providers. Next steps in the procurement would be considered after the urgent care conference had been held. It was uncertain at this stage if any potential change of Government following the General Election would have any impact on the process.

The Committee **NOTED** the position.

43 **HEALTHWATCH BARKING AND DAGENHAM - REPORT OF ENTER AND VIEW VISIT**

In view of the length of the meeting, it was **AGREED** that this item be deferred to the next meeting of the Joint Committee.

44 **URGENT BUSINESS**

The schedule of meetings for the joint Committee for 2015/16 was **AGREED** as follows:

Tuesday 21 July 2015, 2 pm, Barking & Dagenham
Tuesday 20 October 2015, 2 pm, Havering
Tuesday 19 January 2016, 2 pm, Redbridge
Tuesday 19 April 2016, 2 pm, Waltham Forest

Chairman