MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
20 October 2015 (2.00 - 4.15 pm)

Present:

COUNCILLORS

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Barking & Dagenham	Adegboyega Oluwole
Havering	Nic Dodin (Chairman) Gillian Ford and Dilip Patel
Redbridge	Stuart Bellwood and Karen Packer
Waltham Forest	Richard Sweden
Essex	Chris Pond
Healthwatch Co-opted Members:	Ian Buckmaster, Havering Mike New, Redbridge Richard Vann, Barking & Dagenham

Health officers present:
Neil Kennet-Brown, Director of Transformation for Transforming Services Together project
Fiona Smith, Managing Director, Whipps Cross Hospital
Felicia Kwaku, Director of Nursing, Whipps Cross Hospital
Melissa Hoskins, Communications, Barts Health NHS Trust
Clare Burns, Havering CCG
Dr Sarah Hayes
Sarah See, North East London Commissioning Support Unit
Zoe Anderson, North East London Commissioning Support Unit

Scrutiny officers present:
Masuma Ahmed, Barking and Dagenham
Anthony Clements, Havering (Clerk to the Committee)
James Holden, Waltham Forest
Jilly Szymanski, Redbridge
Tudur Williams, Barking & Dagenham

10 CHAIRMAN'S ANNOUNCEMENTS

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

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

Apologies were received from Councillors Peter Chand and Eileen Keller (Barking & Dagenham) and from Councillor Gavin Chambers (Epping Forest). Apologies were also received from Alli Anthony, Healthwatch Waltham Forest.

12 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of pecuniary interests.

13 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Joint Committee held on 21 July 2015 were agreed as a correct record and signed by the Chairman.

Under matters arising, it was noted that the power to refer matters to the Secretary of State was held by the full Council at Havering and Waltham Forest. At Redbridge, this power was held by the Borough Health Overview and Scrutiny Committee (OSC) as delegated by full Council. The power was also held by the Borough Health OSC at Barking & Dagenham and by the County Health OSC at Essex.

The Clerk to the Committee would seek to establish from Barking, Havering and Redbridge University Hospitals' NHS trust (BHRUT) if the two additional A & E consultant posts mentioned at the previous meeting had now been recruited to.

14 TRANSFORMING SERVICES TOGETHER

The Director of Transformation overseeing the Transforming Services Together (TST) project explained that the Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups (CCGs) had been working with Barts Health and neighbouring Trusts to respond to the case for change. The combined population of the three boroughs named was predicted to rise by 270,000 over the next 15 years and it was therefore important health services were altered in order to cope with this.

Prevention was an important issue and the TST team felt that the Health Service should be seen as less of an 'illness service'. Work was therefore also being undertaken with Health and Wellbeing Boards, including the Board covering Redbridge. Out of hospital care also needed to be

considered and the TST project was supportive of the Vanguard project that had recently been launched in Outer North East London. Similar work was also being undertaken in Inner North East London. The NHS 111 service would also be further developed.

In hospital care, it was planned to develop elective surgical wards that would include a higher volume of work at either Newham or Whipps Cross Hospitals. Acute care hubs would be established at each site allowing a more proactive approach to unplanned care. More hot clinics would be used in order to reduce numbers of overnight hospital stays.

It was also planned to increase numbers of low risk births taking place at midwife led units as these facilities had been shown to improve outcomes for low risk births. The programme would also look to improve pathways for brain injuries treated at the Royal London hospital. Work would also take place across the system to improve outpatients, end of life care and diagnostics.

It was accepted that Whipps Cross Hospital was an old site that required fundamental redevelopment as part of the TST programme. The populations of Redbridge, Waltham Forest and West Essex would be involved in development of these plans. A public document outlining the proposals would be available from December 2015 and it was confirmed that a period of public engagement on the plans would follow this.

The predictions for healthcare demand had been based on the Greater London authority population and planned housing data. It was accepted that there were large health inequalities across North East London. Investment needed to be made in GP practices so that people, regardless of language spoken etc, understood how the healthcare system worked.

It was anticipated that an outline business case for the TST proposals would be published in April 2016 and this would be followed by a period of public consultation. Engagement would also continue in the meantime and officers would shortly be attending a meeting in the Epping Forest area to discuss the plans.

Officers agreed that investment was also required in out of hospital care. A shift towards having more consultations by Skype or telephone would result in savings although it was emphasised that investment would also be increased. Barts Health was also continuing to invest in midwifery services.

A pilot of hot clinics at Whipps Cross had been very successful and had saved 50% of non-elective activity. Work was ongoing to remove any disincentives and to ensure that the costs to Barts Health of establishing hot clinics were covered. While some services such as e.g. arthroscopy could be moved to a different site, it was emphasised that outcomes were expected to improve. Officers added that there were unlikely to be large increases in travelling distances from any change of service location.

A Member requested approximate cashflow figures for the proposals but officers emphasised that work had to be carried out in a different way and look for savings from increased productivity etc. There was not the finance available to build a further hospital in North East London and it was therefore necessary to try to transform existing services and ways of working.

The TST programme was looking to change the primary care model and be more proactive. As regards prevention, the programme wished to use schools more in child health and to work with Council public health leads in order to improve areas such as sexual health services.

Information systems had been shared with the GP EMIS system now linked with the system used by Barts Health, allowing the sharing of patient records electronically. Officers would confirm if systems had also been linked with those used in West Essex.

It was accepted that there was a big case for change in primary care but there were no plans to merge the primary and secondary care sectors. Officers also felt that Public Health had a critical role in the TST plans. Work was undertaken with the Barking, Havering and Redbridge University Hospitals' Trust (BHRUT) via the North East London Advisory Group and Outer North East London was also represented on the Commissioning Strategy Group.

The Committee **NOTED** the position.

15 WHIPPS CROSS IMPROVEMENT PLAN

Officers explained that the overall Barts Health improvement plan had been published in September 2015. This had detailed seven workstreams with actions developed by clinicians, patients and partners. Key points of the workstreams included the following:

The Trust wished to provide safe care for patients and, following Care Quality Commission (CQC) findings that safety risk areas were not known, staff were now able to report on incidents on a daily basis via a 'safety huddle'. This was a multi-disciplinary team that allowed identification of which wards needed additional support.

A Quality and Safety Board had also been established for Whipps Cross allowing risks to be escalated as necessary. Priority risk areas at Whipps Cross were pressure care, falls, nutrition and hydration and training for

hospital staff had been arranged on these areas. A safety performance dashboard allowed notification of safety hotspots and successes and partnership work on safety was also in progress with other Trusts such as Salford Royal.

A safe staffing review had resulted in 520 more nursing posts across the Trusts of which 150 were at Barts. This had allowed ward managers to undertake more supervisory work and hence be accountable for the quality of care on their wards. Nursing documentation had been simplified and streamlined and comfort rounds had been introduced allowing more communication with patients.

There was now a revised Trust complaints process which sought to start with a conversation with patients or families and hence bring about an earlier resolution of the process.

As regards end of life care, the CQC had raised some concerns over the Margaret Centre and the need to ensure that appropriate care plans were drawn up for patients nearing the end of life. A refurbishment of the Margaret Centre at Whipps Cross would be completed in mid-November and the Trust was also working with local CCGs to allow more patients to die at home.

It was clarified that the Margaret Centre would definitely reopen after its refurbishment. The Trust felt it needed to identify patients' end of life wishes sooner and had established a team to support more people wishing to die at home. The future of the Margaret Centre depended on the new models of care being developed. Officers added that the Margaret Centre was classified as a palliative care centre rather than a hospice.

It was accepted that workforce issues remained a concern with a lot of bank and agency staff. More than 1,000 staff had recently been appointed across the Trust. Whipps Cross had a target of 100 hires per month and there were currently 84 new employees in the recruitment process. Six recruitment days were also planned. There would also be some international recruitment for the Trust as a whole and an increased number of bank rather than agency staff was now being used.

There were also a number of consultant vacancies but these were being recruited and there had been considerable interest in a vacant A & E consultant post at Whipps Cross. The Trust was looking at incentives to get doctors to return to clinical practice in order to fill vacancies at middle grade levels. Work was also under way with consultants in order to recruit more middle-grade doctors. The hospital managing director also attended the Junior Doctors Forum which allowed doctors to become more involved in hospital projects.

The Whipps Cross site kept data on exit interviews and other Barts Health sites were in the process of compiling this. It was felt that the main reason

given for staff leaving Whipps Cross was to further their career development.

Staffing levels were monitored on a daily and monthly basis and induction arrangements had been improved. The Trust had introduced schemes to improve career development and hence increase staff retention.

Forty patients per day were seen in the new ambulatory care unit at Whipps Cross and the Trust wished to recruit further to extend the operating hours of the unit. Investment had also been made in redeveloping the children's A & E pathway.

The availability of medical records in outpatients had been improved at Whipps Cross from 75% to 96% and this had reached 100% on two days in the last week. All case notes were now bar coded and could hence be tracked with bar code readers. Staff forums had also been set up to consult with relevant staff.

A new leadership operating model had been established with a managing director, medical director and director of nursing for each site, plus appropriate support. A new Trust Chairman had been appointed and further executive recruitment was also in progress. Other initiatives had seen a clinical director appointed for each of the Trust divisions and 40 BME staff start career progression programmes.

Governance changes had included the setting up of review groups for each of the workstreams and there were also quality improvement groups for each site, chaired by the CQC. An Executive Quality Improvement Board and oversight by a Quality Improvement Committee indicated that governance structures were in place at all levels. Monthly progress reports would be published from October 2015 and a communications plan was also in place to update patients, relatives and staff.

Other investment included £2 million on the IT infrastructure at Whipps Cross and £17.8 million on backlog maintenance at Whipps Cross as well two new theatres and a new nine-bed High Dependency Unit. Some £15 million had also been invested across the Trust on medical equipment.

Discussions had taken place with agencies used by the Trust to ensure a good quality of agency nurses and safer induction of bank and agency staff had also been introduced. The nurse in charge of a ward now wore a red badge indicating this and this had been well received by staff and patients.

Further details could be provided of the Trust's new server which would allow the use of more electronic patient records. Officers would also confirm which specialities, other than cancer and frail elderly, held multi-disciplinary team meetings.

It was accepted that there were many patients in acute beds who did not need to be there and that work was therefore needed to reduce delayed

transfers of care. The target was to keep delayed transfers of care to a maximum of 2.5% of the overall bed base but this was currently exceeded at Whipps Cross. The hospital had good engagement with the West Essex CCG on this issue. Officers would provide statistics on the numbers of delayed transfers of care at Whipps Cross.

Officers supported the introduction of boards at each ward entrance with photographs of staff and an explanation of what the various uniforms represented. A similar board identifying senior staff was also on display at the entrance to the hospital. It was also agreed that it was important to have visible leadership with senior management regularly visiting wards and speaking to patients, staff and relatives.

A Guardian Service had been introduced whereby an independent person was available for staff to raise concerns with. Senior hospital management also interacted with staff side representatives in order to build trust and confidence with staff.

Officers confirmed that any discussions on the future of the Whipps Cross site were in the very early stages and no decisions on any potential sale of any of the land on the site had been taken at this stage.

The Committee **NOTED** the update.

16 PRIMARY CARE CO-COMMISSIONING

Officers explained that NHS England remained the statutory commissioner of primary care but had chosen to delegate this responsibility to the four local CCGs. The three BHR CCGs therefore met as a committee in common to discuss commissioning issues and were accountable to NHS England in this regard, rather than to the CCG governing bodies. Representatives from local Health and Wellbeing Boards and Healthwatch organisations were also on the committee in order to help manage any conflicts of interests. Similar governance arrangements existed in Waltham Forest.

Strategy was developed by the Primary Care Transformation Board while it was the role of the Primary Care Commissioning Committee to manage the primary care budgets. The benefits of local decisions on primary care commissioning included better outcomes for patients and better patient access to GP services as well as a reduction in health inequalities. Co-commissioning would also allow more proactive care, more self care for patients and better working with public health.

Information governance rules had been established with NHS England and the CCGs now wished finalise the system for quality reports on practices. A review was also commencing of Personal Medical Services (PMS) contracts for GPs and the outcome of this would be brought to scrutiny.

The use of Government funding received under the Primary Care Estates Strategy was currently being considered and the CCGs would make decisions in due course over how this money would be used.

The CCGs worked on commissioning across Outer North East London where possible and also increasingly with the CCGs in Inner North East London. Officers added that they wished to get the balance right between adopting a consistent approach across London and getting the best outcomes for the local population.

The Committee **NOTED** the update.

17 STROKE REHABILITATION SERVICES

Officers explained that, following the establishment of the Hyper Acute Stroke and Acute Stroke Units, the Barking & Dagenham, Havering and Redbridge CCGs had commenced work on a new stroke pathway in November 2014 to be based at the Queen's Hospital site.

A case for change had been agreed by the CCG governing bodies in June 2015 and current best practice in stroke care had recently been reviewed. The case for change was based on the increase in population expected in the local boroughs and that there was currently a lot of variation in stroke across the boroughs. The proposals would bring better outcomes for patients as well as an improved quality of life for carers. It was also aimed for speech and language therapy to be standard in the new stroke pathway, which was not the situation currently.

The current stroke pathway was felt to be very complex with variations in the quality of care within as well as between boroughs. The next steps would include looking at the financial criteria for the identified options. A pre-consultation business case was due to be taken to the CCGs in November 2015 and public consultation on the changes would then follow.

It was noted that the Essex Health Overview and Scrutiny Committee had last week supported the transfer of stroke services from Harlow to Queen's hospitals. Reassurance was however sought that Queen's would be able to cope with the increased throughput. Officers confirmed that this had been discussed with the West Essex CCG. If more rehabilitation could be completed at home (an aim of the programme) this would mean Queen's would be able to cope with the increased throughput.

The timescale until the new pathway was fully operational depended on the CCGs and the outcome of any consultation but it was expected that the

pathway would not be fully operational until 2016. The new bed capacity had also not been confirmed at this stage but would be included in the pre-consultation business case.

It was confirmed that talks were taking place on the future of the Heronwood & Galleon Unit in Redbridge but this was a separate issue from the stroke pathway.

The Committee **NOTED** the update.

18 **URGENT BUSINESS**

It was noted that a site visit to the NHS 111 officers for this area was being arranged and the Clerk to the Committee would confirm possible dates for this in due course.

Chairman