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JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

3.30 pm	Tuesday 11 October 2011	Council Chamber, Havering Town Hall

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Sanchia Alasia
Councillor Josephine Channer
Councillor Abdus Salam

LONDON BOROUGH OF WALTHAM FOREST

Councillor Laurie Braham
Councillor Nicholas Russell
Councillor Richard Sweden

LONDON BOROUGH OF HAVERING

Councillor Wendy Brice-Thompson
Councillor Nic Dodin
Councillor Pam Light (Chairman)

ESSEX COUNTY COUNCIL

Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Hugh Cleaver
Councillor Joyce Ryan

EPPING FOREST DISTRICT COUNCIL

Brian Sandler (observer status)

CO-OPTED MEMBERS:

Malcolm Wilders

Barking & Dagenham LINk: TBC
Havering LINk: Med Buck
Redbridge LINk: Glynis Donovan
Waltham Forest LINk: Neil Collins

For information about the meeting please contact:
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Waltham Forest

London Borough of Redbridge

Havering LONDON BOROUGH

The London Borough of Barking & Dagenham

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 DECLARATION OF INTERESTS

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

4 MINUTES OF PREVIOUS MEETING (Pages 1 - 8)

To approve as a correct record the minutes of the meeting held on 12 July 2011 (attached).

5 NORTH EAST LONDON NHS FOUNDATION TRUST - TAKEOVER OF OUTER NORTH EAST LONDON COMMUNITY SERVICES & SERVICE DECOMMISSIONING

Discussion with NHS officers.

6 CANCER MODEL OF CARE (Pages 9 - 10)

Presentation from Thomas Pharoah, Implementation Lead Cancer, London Health Programmes (briefing note attached).

7 NHS ESTATES STRATEGY

Presentation from NHS ONEL officers.

8 URGENT BUSINESS

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

Anthony Clements
Clerk to the Joint Committee

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MINUTES OF A MEETING OF THE OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Barking Town Hall
Tuesday 12 July 2011 (3.30 pm – 5.40 pm)

Present: Councillor Sanchia Alasia, London Borough of Barking & Dagenham (in the Chair).

Councillors representing London Borough of Havering: Nic Dodin and Pam Light

Councillors representing London Borough of Redbridge: Stuart Bellwood, Hugh Cleaver and Joyce Ryan

Councillors representing London Borough of Waltham Forest: Nicholas Russell and Richard Sweden

Local Involvement Network (LINk) co-opted members and representatives:

Michael Vann, Barking & Dagenham LINk
Med Buck, Chairman, Havering LINk

Manisha Madhvadia, Co-ordinator, Barking & Dagenham LINk and Joan Smith, Co-ordinator, Havering LINk were also present.

Scrutiny Officers present:
Anthony Clements, Havering (Clerk to the Committee)
Jilly Mushington, Redbridge
Glen Oldfield, Barking and Dagenham

Apologies for absence were received from Councillor Abdus Salam, Barking and Dagenham, Councillor Chris Pond, Essex, Councillor Wendy Brice-Thompson, Havering, Cathy Turland, co-ordinator, Redbridge LINk, Neil Collins, Waltham Forest LINk and Farhana Zia, scrutiny officer, Waltham Forest.

Apologies for lateness were received from Councillors Nicholas Russell and Richard Sweden, Waltham Forest.

Also present were:

Shona Brown (SB) Director of Organisational Change, Whipps Cross University Hospital NHS Trust
Lucy Moore (LM) Transition Director, Barts and East London Healthcare Merger Project
Don Neame (DN) BLT/Newham/Whipps Cross merger team

Carol Drummond (CD) Divisional Director for Women's and Children's Services, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Deborah Wheeler (DW) Director of Nursing, BHRUT
Conor Burke (CB) Director of Commissioning Support, NHS Outer North East London (NHS ONEL)

One member of the public were also present.

The Chairman advised those present of action to be taken in the event of emergency evacuation of the Town Hall becoming necessary.

There were no declarations of interest.

1. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

The minutes of the meeting held on 5 April 2011 were agreed as a correct record and signed by the Chairman.

Councillor Bellwood noted that recent events at BHRUT had reflected the concerns he had raised at the previous meeting.

It was agreed that the clerk to the committee would liaise with health officers and attempt to circulate an update on the diagnostics screening programme and the final report of the Health for North East London Travel Advisory Group.

2. WHIPPS CROSS MERGER WITH NEIGHBOURING TRUSTS

The merger officers felt there were a lot of gains that could result from the merger in terms of patient outcomes. These included a more efficient and effective surgical pathway across the affected hospitals. All the Trusts involved had a need to sustain performance whilst also dealing with financial challenges.

The new Trust – to be called Barts and East London Healthcare could also make a difference to health and health inequalities across East London. This was already shown in initiatives such as the "Small C" campaign covering breast and lung cancer across North East London. The new Trust aimed to invest in technology and research and also aimed to remove organisational barriers in order that for example chemotherapy could be delivered more locally.

Officers felt that the merger would allow stronger A&E and maternity units and emphasised that there would be no impact on Homerton Hospital. The merger was not simply to fund the Barts and the London PFI and it was not assumed that patients would move from Whipps Cross or Newham into Barts. All the Trusts were keen to be partners with stakeholders.

The outline business case for the merger would be taken to Trust Boards in July (2011) and to NHS London in August. It was hoped that the Foundation

Trust would receive full authorisation by March 2014. A public version of the business case or "manifesto" was currently being prepared and an engagement process would take place between July and September 2011.

Officers accepted that there were risks to the merger and wished to identify and mitigate these. The merged Trust would be a large organisation with in the region of 15,000 staff. Councillor Ryan felt it was essential that there were effective staff on wards and that ward cleanliness and appointment issues were got right. LM agreed entirely and explained that best practice would be taken from each of the constituent Trusts. She agreed it was essential to get basic controls right. A new model of leadership and governance for the Trust was also being worked on. It was accepted that senior leadership would be needed on each hospital site.

LM confirmed that modelling for the merger had taken into account the most up to date commissioning plans and that work was being undertaken in close cooperation with NHS ONEL. GP consortia in inner and parts of outer North East London were also involved in the merger plans.

It was anticipated that there would be some displaced activity as a result of the merger as there would be a bigger pool of capacity in the new organisation. LM confirmed it would be for the new Trust's board to decide on any reference in the Trust's Articles of Association preventing support by Whipps Cross and Newham of the Barts and the London PFI. A single access to patient information would have an impact on for example giving thrombolysis drugs to stroke patients more quickly. This would also allow the use of better communication vehicles such as telemedicine.

DN explained that the proposals were for organisational or back office rather than service changes and there was therefore no requirement for public consultation on the merger. DN offered to circulate the legal advice to this effect that had been received. LM emphasised however that the Trusts were committed to a good level of service.

LM could not give an absolute guarantee that the four hospitals involved in the merger would all remain as it had for example already been proposed to close the London Chest Hospital. It was clear however that future health services in the sector would require strong A&E and maternity facilities at both Newham and Whipps Cross Hospitals. Councillor Light was not convinced that all four hospitals would remain in the longer term.

The Chairman thanked LM, SB and DN for their presentation and input to the meeting.

3. MATERNITY SERVICES AT QUEEN'S HOSPITAL

Statement from LINk Representatives

Manisha Madhvadia explained that North East London LINks had become concerned about maternity at Queen's Hospital in January 2011. Publicised cases since then had led to a series of three LINk focus groups on maternity. The LINks had in fact spoken to more than 50 women about their experiences

at Queen's Maternity. The key points arising from these discussions related to the care and welfare of mothers, access to pain relief, staff communication and the availability of patient records. Some staff saw patients as an inconvenience and there were also reports of delays in patient transfer. It was emphasised that this did not apply to all staff and that patients' experiences depended very much on which midwife they saw.

Barking & Dagenham LINK had also found that views of antenatal care were positive but that problems began when labour started. A public meeting about maternity had been arranged for 14 September in Barking. The LINk felt that BHRUT was positive about engagement. The LINks had also given evidence about maternity services to the Independent Reconfiguration Panel.

Med Buck, Chair of Havering LINk explained that concerns over Queen's maternity had been expressed by Havering residents since November 2009. The LINk had visited the department and also met with the director of midwifery and had been told there were no problems with maternity staff at that time. Since then though, there had been a number of tragic incidents and public confidence in Queen's maternity had gone down. Reported failings in the department had also led to a review by the Care Quality Commission.

In January 2011 there were further reports of births occurring in triage and in a corridor. These had not been confirmed by BHRUT at the time. Havering LINk had met with the Trust chief executive but had been unable to obtain much information. Havering LINk had written to BHRUT on 8 April but, as this letter had not been answered within 28 days, had referred the matter to the JOSC and advised BHRUT that this was the position. A response had in fact been received from BHRUT on 5 June but latest feedback indicated that the situation in maternity had not improved. The LINk felt that hospital should be a safe place to provide care.

Havering LINk had received some positive feedback on Queen's maternity but 90% had been negative. Havering LINk would be doing an announced enter and view visit to maternity in the next two weeks. It was clarified that Barking & Dagenham and Redbridge LINKs would be conducting enter and view visits at a later stage in order to view improvements that the Trust had implemented.

<u>Response from BHRUT</u>

DW gave a full and specific apology for the delay in replying to the LINKs' letter which had unfortunately dropped through the internal BHRUT process. The Care Quality Commission (CQC) had visited Queen's maternity in January 2011 and issued a warning notice in March. An action plan covering staffing and midwifery had been signed off with NHS ONEL and the CQC.

The Trust was keen to recruit midwives with the right approach and attitude to looking after women. Monthly meetings were being held between BHRUT and NHS London who were satisfied with progress. Meetings were also held fortnightly with the principal commissioners – NHS ONEL.

A telephone triage system had been put in place to reduce the overall number of women coming to the unit. 80% of women arriving at triage in the last week

had been seen within 15 minutes but the aim was to raise this figure to 98%. Some women were sent home by triage if they were deemed not ready to give birth while others were sent for further assessment by doctors in the observation and assessment unit. 94% of patients in the unit in the last week had been seen within one hour.

The time taken for women to receive pain relief – both pethidin and epidurals was monitored by the Trust on a weekly basis. Epidurals required an anaesthetist to administer and job plans for this function were being reviewed. A total of 26 midwives had started in the last month with 14 starting next month and a further 21 booked for interviews. Midwives had been recruited from Ireland, Italy and the UK although the lead in time for employees to start with the Trust could be up to three months. AD felt that people wished to work at BHRUT in order to make a difference and a new matron and consultant midwife had also been recruited.

Staff surveys had been conducted with midwives and staff spoke to all patients coming through the unit with the aim of raising public confidence. There were more tours of the unit that women could undertake and two Havering Councillors had visited the maternity unit that morning.

DW felt that more positive feedback on the service was now being received. The CQC was in fact now investigating the whole Trust. The report from the first, general CQC inspection would be released shortly. There would be up to 20 CQC investigators on site for the next inspection. The investigators would be mainly doctors and nurses which DW felt was a good thing. The Trust had invested in 21 new maternity posts in order to keep up with rising birth rates but DW accepted these measures should have been implemented a year ago.

CD explained that there was now an expanded maternity education team that worked alongside new midwives. New midwives were not included in the maternity staffing figures until they had been signed off as competent. CD added that student midwives usually wished to stay with the Trust. There was now less tolerance of poor staff attitude and a stricter performance management regime.

It was clarified that a maternal death referred to any woman who died in a period from the early stages of pregnancy to one year after birth. This term was used even if the precise cause of death was not maternity related.

CD emphasised that the Trust was now trying to keep pace with the rising birth rate in terms of the number of midwives it was recruiting. The Trust's approach had changed in November 2010 and recruitment agencies had been recruited to assist with this. The midwives recruited overseas all spoke excellent English. All midwives were interviewed in English and required to make a presentation in English. Midwives were also required to pass a written test in English. DW added that midwifery training was standardised across Europe and Italian midwives could therefore register straightaway. There was a four month adaptation programme for Irish midwives. Councillor Ryan offered to share with the Joint Committee correspondence on this issue with BHRUT and NHS Redbridge.

Councillor Bellwood pointed out that Averil Dongworth, the Trust chief executive had said at the Committee's previous meeting that 50 midwives had been recruited and that these figures did not seem to match with those given at the meeting today. DW responded that the Trust had instituted a commonsense approach to the high volumes of anticipated births in Outer North East London. She accepted that the Trust should have done this earlier and a further issue was to ensure staff were kept up to date with good practice. The CQC report had said that midwives felt deskilled in some areas and, as a result, the Trust had taken on an Associate Head of Midwifery who was reviewing all systems and processes. Individual training needs assessments were also being completed for all staff.

As regards recruitment numbers, the 26 midwives who had now started were part of the cohort of 50 that Averil Dongworth had referred to. There were also ongoing interviews and it was acknowledged that some applicants also withdrew during the recruitment process. A further 44 midwives had job offers to start between now and October. Twenty-one further midwives were being interviewed. Full exit interviews were also carried with any midwives who left the organisation.

Malcolm Wilders asked why issues weren't dealt with by management prior to the publication of the CQC report. DW replied that the Trust had recognised last autumn that the then process of midwifery recruitment was not working. Recruitment agencies were therefore engaged but a whole service approach had also been instigated. She accepted that this should have been done at an earlier stage. DW also agreed that it was important that the right quality of people be recruited.

Med Buck felt that the LINks were happy that BHRUT was taking the matter seriously and remedying the situation. He wished to see results whatever the cost. CD confirmed that in the last two months, six midwives had been suspended at BHRUT and were currently going through the disciplinary process.

CD emphasised that women should not be kept in triage. Triage assessments were carried out by a midwife and the assessments meant that labour beds were no longer blocked. Lower risk cases would be diverted to King George if Queen's was approaching capacity. This allowed more 1:1 care to be given to women in labour.

Maternity staffing levels had been changed at the beginning of May raising the number of midwives per shift at Queens from 12 to 16. Gaps would be filled with temporary staff if necessary. Numbers of midwives available were identical on both day and night shifts.

It was **agreed** that the Committee should revisit the issue of maternity at Queen's Hospital in order to both take an update from BHRUT itself and receive feedback from the LINks on the outcome of their enter and view visits.

The Chairman thanked CD, DW and the LINk representatives for their input to the meeting.

4. COMMITTEE'S WORK PROGRAMME

Councillor Ryan suggested she circulate a list of visits she was setting up to various health facilities as many of these could be done jointly with other boroughs. The Committee **agreed** this would be useful and thanked Councillor Ryan for her suggestion.

Members felt that it would be useful to look at public health across the four boroughs and also the provision of primary care. This would tie in with the new Council responsibilities for public health due to be introduced in the forthcoming Health Bill. CB suggested that this could be achieved by bringing to the Committee summaries of the annual public health reports for each of the boroughs when these were published in April 2012. It was felt that it may also be useful to jointly scrutinise the QIPP report produced by NHS ONEL.

It was therefore **agreed** to move public health issues to the Committee's April meeting and primary care to its January meeting. It was also **agreed** to scrutinise the QIPP report at a future meeting, once this had been published.

It was **agreed** to retain the current start time of meetings of the Joint Committee of 3.30 pm.

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LondonHealth PROGRAMMES

NHS London

Implementing the cancer model of care: Briefing – September 2011

1. In December 2009 a case for change for cancer services in London was published. It showed that the lack of progress in implementing co-ordinated cancer services across the capital means that services may be excellent in some instances but is hugely variable. This has an impact on clinical outcomes and means that patients often experience fragmented care.

2. A proposed model of care was then published in August 2010. The proposals were developed over a 12-month period by over 45 committed cancer clinicians from the capital and an active patient panel and took into account national and international evidence and best practice. The model of care details clinically-developed solutions that will ensure that radical improvements are made to London's cancer services.

3. The proposed model of care was the subject of a three-month engagement process with GPs, the public and Local Authorities. The feedback received was supportive and the proposals are now being taken forward.

4. The implementation of this model of care is being led by Rachel Tyndall, former NHS North Central London Chief Executive, who has been appointed as the Senior Responsible Officer and Chris Harrison, Medical Director of The Christie, Manchester's specialist cancer hospital, as the Clinical Director. They are supported by an implementation team at London Health Programmes, the five cancer networks in London and staff at the London Specialised Commissioning Group.

5. The implementation programme has workstreams to address the areas indentified for improvement in the model of care, including spreading best practice, improving radiotherapy, and ensuring early diagnosis of cancer.

6. The case for change highlights that the earlier that cancer is diagnosed and treated, the greater a patient's chance of survival and improved quality of life. It is estimated that 1,000 lives per year could be saved in London through earlier diagnosis.

7. A public health and primary care working group has therefore been established to work with GPs, public health professionals, commissioners and existing cancer networks to build on the recommendations in the model of care to improve public awareness of cancer symptoms, increase GP access to diagnostics, maximise effectiveness of referrals to secondary care, improve the patient pathway and reduce health inequalities.

8. This working group has developed a strategy for improving early diagnosis and driving the ongoing implementation of the National Awareness and Early Diagnosis Initiative (NAEDI). This strategy can now begin to be implemented.

9. Central to the implementation programme is the expectation that providers will work together in *integrated cancer systems* to ensure that patients experience seamless care. These systems, rather than individual organisations, will be commissioned to deliver pathways of care from next April.

10. An integrated cancer system is defined as a group of NHS hospital providers that comes together in a formal, governed way to provide services across the whole of the cancer pathway. The integrated cancer system will be commissioned to provide cancer care based on defined care pathways to meet patients' needs.

11. A workstream has been established to explore and develop the commissioning process for integrated cancer systems. The working group will develop commissioning specifications for pathways including pathway contracting arrangements and tariffs, and establish key measures for pathways and integrated cancer systems.

12. To facilitate the development of these systems the implementation team worked closely with hospital providers to develop a specification against which providers submitted their proposals to become integrated cancer systems. The specification states that systems should have clear organisational and integrated governance systems and structures with clear lines of accountability and responsibilities for all functions.

13. Two groups of hospital providers have submitted their proposals to become integrated cancer systems: one encompassing the providers in north east and north central London (London Cancer), and the other the providers in south east, south west and north west London (working title 'The Crescent').

14. These submissions have been assessed against the criteria set out in the integrated cancer system specification. Both the strength of the proposed integrated cancer system arrangements and the strength of service proposals have been assessed.

15. Following its assessment of the two sets of integrated cancer system proposals an evaluation panel concluded that good progress had been made and that both proposed systems should be authorised, subject to agreed action plans for their further development. These conclusions, as well as recommendations on the areas in each proposal where further work was needed, were endorsed by the NHS London Delivery Group in September.

16. The implementation team has been working with both of the systems to develop detailed action plans outlining how the systems will work alongside commissioners to continue their development. These action plans will be agreed between integrated systems and commissioners in early October.

17. The assurance phase was the first step in an ongoing process during which commissioners and providers will work together up to and beyond April 2012 to ensure that the recommendations as set out in the agreed model of care for cancer services in London are implemented.

18. The integrated systems are continuing to develop their service plans. The implementation team will continue to work with clusters, GPs and commissioners to ensure that local plans are aligned to the implementation programme. Once possible local implications are clear then they will be presented to local authorities.