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Health and Social Care Scrutiny Sub (Community and Children's Services) Committee

Date: **TUESDAY, 16 JULY 2013**

Time: **1.45pm**

Venue: **COMMITTEE ROOMS, WEST WING, GUILDHALL**

Members:
Randall Anderson
Deputy Billy Dove
Wendy Mead
Dhruv Patel
Judith Pleasance
Emma Price

Enquiries: **Julie Mayer**
tel. no.: 020 7332 1410
julie.mayer@cityoflondon.gov.uk

Lunch will be served in the Guildhall Club at 1pm

John Barradell
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES**

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

3. **MINUTES**
   To approve the public minutes and summary of the Health and Social Care Scrutiny Sub Committee held on 20 November 2011

   For Decision
   (Pages 1 - 4)

4. **ELECTION OF CHAIRMAN**

   For Decision

5. **ELECTION OF DEPUTY CHAIRMAN**

   For Decision

6. **ELECTION OF INNER NE LONDON JOINT HEALTH OVERVIEW AND SCRUTINY REPRESENTATIVE**

   For Decision

7. **TO CO-OPT A HEALTHWATCH REPRESENTATIVE TO THE HEALTH AND SOCIAL CARE SCRUTINY SUB COMMITTEE**

   For Decision

8. **TOBACCO CONTROL ALLIANCE PROJECT PLAN**
   Report of the Director of Community and Children's Services

   For Information
   (Pages 5 - 14)

9. **PROGRESS UPDATE ON THE MINOR INJURIES UNIT FOR THE CITY OF LONDON – REPORT OF BARTS NHS TRUST**

   For Information
   (Pages 15 - 16)

10. **HOMERTON UNIVERSITY HOSPITAL QUALITY ACCOUNTS UPDATE**
    Report of the Director of Community and Children's Services

    For Decision
    (Pages 17 - 22)

11. **BART'S HEALTH TRUST QUALITY ACCOUNTS UPDATE**
    Report of the Director of Community and Children's Services

    For Information
    (Pages 23 - 38)

12. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

13. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY AND CHILDREN'S SERVICES) COMMITTEE

Tuesday, 20 November 2012

Minutes of the meeting of the HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY AND CHILDREN'S SERVICES) COMMITTEE held at Guildhall, EC2 on TUESDAY, 20 NOVEMBER 2012 at 1.45 pm

Present

Members:
Revd Dr Martin Dudley (Chairman)
Angela Starling (Deputy Chairman)
Nicolas Cressey
Peter Leck
Deputy Joyce Nash
Deputy Wendy Mead
Vivienne Littlechild
Jakki Mellor-Ellis

Officers:

Caroline Webb	-	Town Clerk's Department
Joy Hollister	-	Director of Community & Children's Services
Farrah Hart	-	Community and Children's Services
Leiann Bolton-Clarke	-	Community and Children's Services
Shaista Afzal	-	Community and Children's Services
Gillian Robinson	-	NHS North East London and the City

1. **APOLOGIES**
   Apologies were received from Deputy Henry Jones and Steve Stevenson.

2. **DECLARATIONS BY MEMBERS OF PERSONAL AND PREJUDICIAL INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA**
   City of London resident Members declared personal interests in all the agenda items as users of the services under discussion. They did not consider these to be prejudicial interests.

3. **MINUTES**
   The public minutes and summary of the meeting held on 25 September 2012 were agreed as a correct record.

   Matters Arising

   Minor Injuries Unit
   The Chairman informed the Sub Committee that he had met with Toby Lewis, Deputy Chief Executive and Development Director, Barts Health NHS Trust and

confirmed that a report would be submitted to the Sub Committee in due course regarding the Minor Injuries Unit.

4. **OFFICER UPDATE**

The Director of Community and Children's Services updated Members on the following:

- The Health and Wellbeing Board governance arrangements would be considered at the December meeting of the Court of Common Council, with Members due to be appointed to the Board at the January 2013 meeting.
- The Substance Misuse Partnership had moved from the Town Clerk's Department to the Community and Children's Services Department on 12 November 2012.
- The process of appointing a Director of Public Health was on going and would be made in partnership with the Hackney and possibly Tower Hamlets.

5. **JOINT STRATEGIC NEEDS ASSESSMENT 2012**

The Sub Committee received a report of the Director of Community and Children's Services updating Members on the progress of the 2012 Joint Strategic Needs Assessment which is a statutory requirement for local authorities.

RECEIVED

6. **JOINT HEALTH AND WELLBEING STRATEGY**

The Sub Committee received a report of the Director of Community and Children's Services outlining the development of the draft City of London Joint Health and Wellbeing Strategy, a requirement of local authorities by the Health and Social Care Act 2012.

Members discussed how the proposed priorities would be measured over a period of three years and the difficulties of obtaining accurate figures of City residents and the public health services they utilise. An action plan was being developed and definitions were being created to define each of the services. There was a small dependency on services reporting issues back to the City, for example, through City LINk.

A Member highlighted the need to address the attitudes toward drug use of City workers and would circulate a urine analysis report to Farrah Hart for her information.

There was currently no shadow Health and Wellbeing Board Member responsible for the harmonisation of the Planning and Transport strategies with the Health and Wellbeing strategy but the Sub Committee were informed that this would be addressed. A reference to the Policing strategy would also be added.

RECEIVED

7. **SUBSTANCE MISUSE PARTNERSHIP**

The Sub Committee received a report of the Director of Community and Children's Services outlining the transfer of the Substance Misuse Partnership (SMP) from the Town Clerk's Department to the Department of Community and Children's Services and highlighted the range of services and issues covered by the SMP.

Members discussed the possibility of surveying businesses within the City to investigate whether they would assist in funding health care provisions for employees in regards to drug use.

RECEIVED

8. **TOBACCO CONTROL ALLIANCE UPDATE**

The Sub Committee received a report of the Director of Community and Children's Services outlining the three main themes the Tobacco Control Alliance had focused on during the past year.

Members were informed that the Fixed Penalty Notices were £80 and were issued by Street Environment Officers. Discussion took place regarding a number of passages and similar restricted pathways in the City, such as Barley Mow Passage, that were technically defined as an enclosed space but often had smokers located within them.

The Sub Committee supported the Chairman to act as an advocate for the work of the Tobacco Control Alliance.

RESOLVED: That:

i. the work of the Tobacco Alliance over the past year be considered and appraised; and
ii. the programme of work proposed within the report be considered and endorsed.

9. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

There were no questions.

10. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

There were no items of urgent business.

11. **EXCLUSION OF THE PUBLIC**

RESOLVED - That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act as follows:-

Item No.	Exempt Paragraph(s) in Schedule 12A
12	3
13-14	-

12. **NON-PUBLIC MINUTES**
The non-public minutes of the meeting held on 25 September 2012 were agreed as a correct record.

13. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
There were no non-public questions.

14. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**
There were no non-public items of urgent business.

The meeting ended at 2.53pm

Chairman

Contact Officer: Caroline Webb
tel. no.: 020 7332 1416
caroline.webb@cityoflondon.gov.uk

Committee(s):	Date(s):	Item no.
Health and Wellbeing Board Health and Social Care Scrutiny	4th July 2013 16th July 2013	
Subject: Tobacco Control Alliance Project Plan		Public
Report of: Director of Community and Children's Services		For Information
Ward (if appropriate): All		

Summary

Smoking creates major health, economic and social burdens within the City of London. Comprehensive tobacco control efforts can impact on health inequalities, reduce the economic burden on society and reduce the death, disease and disability caused by smoking. Effective tobacco control needs to be driven by local priorities, local action and local leadership. The Health and Wellbeing Board has recognised the importance of Tobacco Control at a local level by identifying it as a key priority.

The City Tobacco Control Alliance has developed continued strong leadership which has resulted in a systematic approach to delivering an effective and comprehensive tobacco control programme.

The key projects for this year, as agreed by the Alliance members, which will impact upon our residents and workers include:

- Healthy Workplace Offer
- CoL Smokefree Policy
- Smokefree Outdoor Areas
- Smokefree Homes and Cars
- Fixed Penalty Notice Referral Incentive Initiative

These projects will be implemented during scheduled, staggered times of the year to ensure capacity to deliver is not compromised. Internal capacity at Alliance level is essential for the sustainability and efficacy of the tobacco control work programme.

Recommendations

The Board is asked to note the smoking cessation performance for 2012/13 and the key projects for 2013/14

Main Report

Background

1. Nationally, smoking prevalence has declined over the past decade though in the last three years of recorded data, 2007 to 2010, this decline has stopped, for both men and women. Nationally, 21% of men and 20% of women in England smoked. In London, 18.9% of men and women smoke.

2. Although data is not available on smoking prevalence among the residents of the City of London. In 2009, a study commissioned by NHS City and Hackney to investigate City workers' smoking habits and their views of the stop smoking services revealed that 54% of City workers smoked. This gave an estimated 170,000 smokers. However, a 2012 report, commissioned by the City Corporation and NHS North East London and the City of the health behaviours and needs of City workers, shows a smoking prevalence of 24.7%. This is significantly higher than the national average of 20% and London average of 18.9%. However, it needs to be remembered that this is a specific demographic that is concentrated in the City only during business hours.

3. Smoking is a major public health concern: both nationally and within the City. It is the biggest single preventable cause of death and disease in the UK. Up to 15% of deaths in the City are related to smoking. Smoking not only causes premature death but impacts on people's wellbeing and hinders their ability to be economically active. The 2009 study found that a key correlate of smoking is stress - 34% of respondents gave this as the reason for smoking. 44% of respondents said they smoked mainly at work and, of these respondents, 37% smoke because of stress and 22% to help with keeping alert. Only 15% of respondents smoke mainly because they enjoy it. A reduction in the number of smokers in the workforce would result in employees who are more motivated and free from the illnesses associated with smoking. This in turn would help to reduce unplanned absenteeism and increase productivity, morale and staff retention. In London, the estimated cost of lost productivity from smoking related sick days is £356 million and the estimated output lost from early deaths is £583million.

4. The City of London Corporation's Department of Built Environment (formerly, Department of Environmental Services) spend around £4m per annum in the provision of street cleansing services. Smoking related litter (SRL) represents the most significant litter problem in the City.

Current Position

5. In 2012/13 a total of 1170 people accessed the smoking cessation services across the City and 611 went on to successfully quit (quit at four weeks). A network of services is available to support smokers wanting to give up; all Boots stores have a fully trained Stop Smoking Advisor in house, three drop in clinics also run across the City at the Guildhall, Barbican and Portsoken Health Centre. The Service has also provided workplace clinics in 9 different local businesses.

6. All services should be achieving a Department of Health minimum recommended quit rate of 35%. In 2012/13, Pharmacies and Level III Service achieved a very high success rate of 51% and 61% respectively. The Neaman Practice however, only achieved a 20% quit rate. (See Appendix 1).

7. A very successful New Year price promotion is run across all Boots stores throughout the month of January. This initiative allows clients to access the smoking cessation medication for free, as well as the usual free support provided. This is a very popular promotion due to the number of smokers' New Year resolutions to quit smoking and this presents itself at the ideal time. In 2012/13 41% of those who accessed the Boots service did so in quarter 4 and 42% of the total number of four week quitters from Boots was achieved in quarter 4.

8. 'Stoptober' was the first Department of Health mass quitting campaign in October 2012. The main communication message was to challenge smokers to quit for 28 days as research shows that people who stop for 28 days are five times more likely to remain smokefree. All Boots stores advertised the campaign and the Alliance worked with the City of London Cleansing department to utilise the recently installed Renew on-street recycling bins, which have incorporated within them, digital display screens. At the time of the campaign there were around eighty five of these units located in high foot fall areas to gain maximum exposure to passers-by. Each of the units has two screens giving one hundred and seventy viewing locations. The Stoptober branding was displayed every 2 minutes from 12:00-16:59 from 21st September to 30th October.

9. The Tobacco Control Team has delivered a series of brief intervention training sessions with the City of London Corporation staff. This enables attendees to bring up the subject of smoking with clients and to refer smokers to local smoking cessation services. The Team also trained staff from the Substance Misuse Partnership to 'Level II' to provide them with the necessary skills to support clients through a quit attempt.

10. The Tobacco Control Team has presented at the Environmental Best Practice Meeting, part of the Clean City Awards Scheme, to engage with businesses in order to reduce their smoking related litter and encourage a healthier workforce by supporting employees who want to quit smoking.

Options

11. The TCA has grown in its infancy as more partners and stakeholders understand the impact of tobacco at a societal and medical level. The key projects the Alliance will be delivering this year will benefit our residents and workforce and ensure that the City of London is a leader in Tobacco Control.

Workforce

12. Healthy Workplace Offer

Key strategic leads will work with the Director of Public Health to coordinate and deliver the offer to businesses set out in the report on Workplace Health, also on this agenda. Offers will be made through the Clean City Awards applicants, Health and Safety and enforcement links. A limited number of businesses will be approached to gauge demand and capacity. If the offer proves popular, capacity will need to be evaluated to ensure continued delivery.

13. CoL Smokefree Policy

The Alliance will work with Corporate HR to develop and implement a comprehensive and robust Smokefree Policy. This will help to demonstrate the Corporations commitment to adopting the public health responsibility deal 'Health at Work' pledge set out in the report on Workplace Health. The Policy will build on existing smokefree legislation and will have clear benefits to the Corporation:

- a healthier workforce
- reduction in unplanned absenteeism
- increased productivity
- reduction in smoking related litter

- reduced fire risks
- increased compliance with health and safety responsibilities

The policy will include information and details of local stop smoking services, allowing staff time off to attend these services, prohibiting smoking within 5 meters of Corporation buildings, encouraging staff not to smoke wearing their ID badges and protecting staff who visit clients' homes from second-hand smoke by asking the client not to smoke up to one hour before the scheduled visit. The Corporation's Smokefree Policy will become an exemplar policy to local businesses.

Residents

14. Smokefree Outdoor Areas

Smokefree children's play areas:

Many areas nationally are creating smokefree playgrounds using voluntary codes and some are considering whether seeking local regulatory powers would be practicable. The benefits of stopping smoking in playgrounds will:

- Support the de-normalisation of smoking
- Reduce the risk of exposure to second-hand smoke
- Reduce smoking related litter and threat of cigarette butts
- Reduce the risk of fire

The Alliance will identify gardens and estates in the City where children's play areas are present and seek to make these spaces smokefree. Residents, users and stakeholders will be consulted and included in the process.

Smokefree outdoor sporting areas:

Introducing smokefree outdoor sporting areas will have similar benefits to smokefree playgrounds. The Alliance will work with local stakeholders to implement a voluntary smokefree code in designated areas for sporting activity in the City.

15. Smokefree Homes and Cars

The national smokefree homes and cars campaign is in its second year and is highlighting the harmful effects of smoking in the home and car. Implementing a local campaign will further strengthen the messages. The campaign will be implemented in partnership with estates and residents to encourage residents to pledge to keep their home and/or car smokefree to protect their family, friends and pets from the dangers of second-hand smoke.

16. Fixed Penalty Notice (FPN) Referral Initiative

The Alliance will explore the possibility of introducing an FPN referral initiative to smokers who drop cigarette butts on the street. Those smokers who are fined will be offered the opportunity to have their fine reduced or withdrawn by attending a local stop smoking service. This would raise awareness of local stop smoking services to the public, increase referrals into these services as well as broker good relations between the public, businesses and the street enforcers.

Conclusion

17. The Health and Wellbeing Board already recognises the harm caused by tobacco, evidenced by identifying tobacco control as one of its key priority areas. The work plan for 2013/14 is ambitious yet deliverable and uses a whole-systems approach which has solid evidence base in reducing the harm caused by tobacco.

Contact:

Gillian Robinson, Acting Tobacco Control Programme Manager
City and Hackney Public Health Team | gillian.robinson@hackney.gov.uk | 020 8356 2727

Appendix 1

Stop Smoking Services Targets and Performance Data 2012/13

City and Hackney target – 2220 four week quitters
Corporation of London target – 610 four week quitters

	Annual Target*	2011-12 Performance				Projected Targets 2012-13				Quarter 1		Quarter 2			Quarter 3			Quarter 4			SQD Grand Total	Quitter Grand Total	% Achieved	Quit Rate %
		Qt 1	Qt 2	Qt 3	Qt 4	Qt 1	Qt 2	Qt 3	Qt 4	Setting a quit date	Successfully Quitting	Reprofiled Target	Setting a Quit Date	Successfully Quitting	Reprofiled Target	Setting a Quit Date	Successfully Quitting	Reprofiled Target	Setting a Quit Date	Successfully Quitting				
Community City	**100**	35	33	37	25	25	25	25	25	50	**34**	16	49	**30**	11	43	**27**	9	35	**17**	**177**	**108**	**108%**	61%
Pharmacy (City)	**500**	70	82	52	308	100	100	100	200	127	**64**	136	144	**72**	164	109	**54**	310	588	**308**	**968**	**498**	**100%**	51%
Primary Care City	**10**	1	0	0	0	3	3	3	3	8	**2**	3	5	**0**	6	7	**2**	6	5	**1**	**25**	**5**	**50%**	20%
Total	**610**	**106**	**115**	**89**	**333**	**128**	**153**	**128**	**228**	**185**	100	**155**	**198**	**102**	**181**	**159**	**83**	**325**	**628**	**326**	**1170**	**611**	**100%**	52%
CoL Target	**610**									**153**	**-53**	**153**	**-51**	**-104**	**153**	**-70**	**-174**	**153**	**173**	**-1**				

*"Community" – Level III Specialist Service
"Pharmacy" - 15 Boots stores and 1 independent pharmacy in the City
"Primary Care" – the Neaman Practice

Appendix 2

2012/13 Action Plan

Actions	Lead Officer	Partners	Milestones	Timescales
Healthy Workplace Offer	Health and Wellbeing Policy Development Manager	Tobacco Control Team Substance Misuse Development Officer	Development of Offer Presented to X no. of businesses	August 2013 October 2013
CoL Smokefree Policy	Acting Tobacco Control Programme Manager	Assistant Director of Community and Children's Services Department Corporate HR Tobacco Control Team	Corporate HR to include in programme of reviewing/revising policies Draft policy written Consultation Policy launch	July 2013 July 2013 September 2013 October 2013
Smokefree Children's Play Areas	Acting Tobacco Control Programme Manager	Tobacco Control Team Head of Barbican and Estates	Development of campaign Appropriate signs assembled Campaign launch	October 2013 November 2013 November 2013
Smokefree Outdoor Sporting Areas	Acting Tobacco Control Programme Manager	Tobacco Control Team Open Spaces Department Fusion Leisure Centre	Development of campaign Appropriate signs assembled Campaign launch	October 2013 November 2013 November 2013

Smokefree Homes and Cars	Acting Tobacco Control Programme Manager	Tobacco Control Team Head of Barbican and Estates	Development of campaign Joint promotional event	November 2013 February 2014
Fixed Penalty Notice Referral Initiative	Assistant Director – Street Scene and Strategy	Tobacco Control Team	Exploration of procedures Launch (dependent on discussions)	July 2013 November 2013

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Barts Health NHS
NHS Trust

Progress update on the Minor Injuries Unit for the City of London
01 July 2013

1. **Purpose**
   Following a meeting on 19 November 2012 between Dr Martin Dudley (Chairman of the Health and Social Care Scrutiny Sub Committee), Toby Lewis (Development Director, Barts Health) and Rebecca Carlton (Operations Director, Emergency and Acute Medicine Clinical Academic Group, Barts Health), it was agreed that Barts Health NHS Trust would provide the City of London Health and Social Care Scrutiny Sub Committee with a written progress update on the Minor Injuries Unit (MIU) at St Bartholomew's Hospital. This progress report was provided to Committee officers on 17 January 2013.

   Barts Health now welcomes the opportunity to discuss the updated report (re-submitted 24 April and 01 July 2013) at the City of London Health and Social Care Scrutiny Sub Committee on 16 July.

   To note: Toby Lewis, Development Director is no longer with the organisation. MIU developments are led by the Emergency and Acute Medicine Clinical Academic Group. All discussions will also need to be supported by the emerging long-term strategy for Barts Health.

2. **Overview**
   Barts Health NHS Trust is committed to providing equitable access to urgent and unscheduled care for all of the population we serve. We endeavour, along with our partners in primary care and with neighbouring NHS Trusts, to ensure a balance of access to these services for our resident and commuting populations.

   When required, we have operationally adjusted how access is provided so that the greatest number of patients can access our services as and when they need to.

3. **Minor Injuries Unit (MIU)**
   In April 2012, the new Trust reviewed the activity at the Minor Injuries Unit (MIU) at St Bartholomew's Hospital.

   A typical patient profile that would present at the MIU include those requiring attention for acute minor wounds, wounds requiring skin closure by glue or suture, superficial burns, superficial animal bites, limb injuries (upper limb clavicle to fingertip) and lower limb (knee to toe). Other injuries are assessed, provided with first aid and if necessary redirected to the most appropriate primary or emergency care provider.

   It was evident from the review that attendances at the MIU peaked around 11am, but then significantly tailed off in the afternoon. Prior to May 2012, there was rarely more than an average of 2 -3 patients per hour seen at the St Bartholomew's MIU. In the six months from 1 October 2011 to 31 March 2012, a total number of 1574 patients

were seen between 2pm and 8pm. This totals an average of only 2.15 patient attendances per hour in the afternoons across the winter period.

Conversely, the demand at the Royal London A&E department increases in the afternoon and provides services to a significantly greater part of its local population.

A pilot scheme to transfer the afternoon service of the MIU from St Bartholomew's Hospital to the Royal London Hospital was introduced to test if this would result in better use of limited resources. (The Royal London Hospital is approximately 1.09 miles from St Bartholomew's Hospital). It was agreed that the scheme would be reviewed after a few months to evaluate the impact of the change.

4. Outcomes

Since the change was introduced in May 2012, an audit has been undertaken and provisionally concluded that in order to match demand for urgent care the morning opening times at the MIU should be maintained. This revised service has been in place until the present.

Following this review, and with the introduction of the national 111 service in April, Barts Health planned to re-introduce an 8am - 4pm service at The St Bartholomew's MIU*. This will be supported by a revised staffing rota, enhanced non clinical roles and a full rotation programme for staff based at the Royal London Hospital. We will aim to ensure that whilst patient access to the services at St Bartholomew's MIU remains consistent, we can also be flexible and adapt the model to meet higher demand for services at the Royal London from 2pm, whilst still retaining an Emergency Nurse Practitioner service at the MIU until 4pm. It is not intended that this service is ad hoc or inconsistent in relation to its opening times.

*Since the original report in January, Barts Health are pleased to inform the committee that we have reverted back to the standard opening times and are continuing to validate and audit attendances and activity at the unit.

5. For discussion

In the longer term, the Trust is interested to work with local commissioners and stakeholders to develop an improved service model, including options to support access to therapies or primary care services, for the St Bartholomew's MIU as part of the new build development. The Trust is now well represented on the newly established Urgent Care Board for Tower Hamlets as a forum to facilitate this.

Barts Health also welcomes the opportunity for an initial discussion with the committee around the development and partnership opportunities available. To facilitate this, Lucie Butler, Head of Nursing, Emergency Care and other colleagues from the clinical academic group will be attending the meeting on the 16 July.

Committee:	Date(s):
Health and Social Care Scrutiny	16th July 2013
Subject: Homerton University Hospital Quality Accounts Update	**Public**
Report of: Director of Community and Children's Services	**For Decision**

Summary

This report sets out the approach the Corporation has taken to scrutinising the Homerton University Hospital Quality Accounts in partnership with the London Borough of Hackney and requests Member representation at the Health in Hackney Scrutiny meeting to meet with representatives of the Hospital.

Recommendations

Members are asked to:

- Endorse the approach taken to scrutinising the Homerton University Hospital Quality Accounts.
- Note that the Homerton University Hospital will be providing a written response by the end of August 2013.
- Agree that the Inner North East London Joint Health Overview and Scrutiny (INEL JOSC) representative attends the October Health in Hackney Scrutiny meeting to discuss the Hospitals response on behalf of the City.

Main Report

Background

1. All NHS Hospitals are required to produce annual quality accounts setting out their approach to all aspects of hospital services. Scrutiny Committees from any geographic area served by a hospital have an opportunity to make comments and raise issues about the accounts. These are included within the final documents submitted to the Department of Health.

Current Position

2. As there were no Health Scrutiny meetings in either Hackney or the City of London during the consultation period for the quality accounts, officers agreed to make a joint written submission to the Homerton University Hospital involving the Inner North East London Joint Health Overview and Scrutiny (INEL JOSC) representative for LB Hackney (Cllr Luke Akehurst) and for the City of London Corporation (CC Vivienne Littlechild).

3. The submission is attached as Appendix One to this report. The Homerton have agreed to produce a written response to the document by the 31st August 2013 and to attend the Health in Hackney Scrutiny meeting on 10th October 2013 at 7.00 pm to discuss it.

Proposals

4. Members could ask the Homerton Hospital to attend a separate Scrutiny Committee meeting at the Corporation to discuss the quality accounts but as a joint approach has already been adopted officers recommend that we continue to manage the process in this way.

5. The role of the INEL JOSC representative is to represent the interests of the City in health issues impacting on a wider geographic area so it seems appropriate for the Member fulfilling this role to attend the meeting in Hackney on the Committees behalf. The London Borough of Hackney are agreeable to this arrangement.

Appendices

- Appendix 1 – City and Hackney submission to Homerton University Hospital

Neal Hounsell
Assistant Director Commissioning and Partnerships
T: 0207 332 1638
E: neal.hounsell@cityoflondon.gov.uk

Area J, 2nd Floor
Hackney Service Centre
London Borough of Hackney
1 Hillman St
London, E8 1DY

10 May 2013

Ms Melanie Mavers
Head of Clinical Quality
Quality and Risk Department
1st Floor Brooksby House
Homerton University Hospital NHS Foundation Trust
Homerton Row
London E9 6SR

Dear Ms Mavers

RESPONSE TO QUALITY ACCOUNTS FROM HACKNEY AND CITY OF LONDON SCRUTINY COMMITTEES

Thank you for inviting us to submit comments on the Quality Accounts of your Trust for 2012-13.

We've been giving some thought to our role in commenting on Quality Accounts generally and we've agreed with our scrutiny colleagues at the Corporation of London to send you a joint response.

We've also decided to adopt a more strategic approach to this task and we include below some broader questions which we would like you to answer.

In my letter of 18 March, in response to your enquiry about priorities, we suggested you might give consideration to the following issues which came up during the year in Health in Hackney's work:

- care after discharge: particularly onward referral to community based services for vulnerable clients e.g. dependent drinkers, homeless
- improving communication standards of doctors and nurses and the feedback back to GPs
- levels of noise in the wards

As I explained, Health in Hackney does not meet in May as it is the changeover period when our AGM happens and all committee memberships change, therefore we are asking if you will accept written comments from us. Our Corporation of London colleagues would be grateful for the same response.

After considering your draft Quality Accounts we would be grateful for your response to the following general issues:

a) The Homerton has a well deserved reputation but with mergers happening around you, this makes you vulnerable as a smaller trust. How much have you examined the issue of how small can you be (compared to your neighbours) before you find you are no longer viable and how are you responding to this in terms of your long term strategy for the Trust?

b) How is the creation of the newly merged Barts Health affecting your organisation?

c) The workforce pressures that come with the current trend for increasing centralisation of treatment pathways could make some units in some hospitals no longer viable. How will you respond to these emerging trends within the NHS where there are plans for centralising urological cancer surgery provision, for example?

d) The Francis Inquiry has set in train plans to better protect whistle blowers. We feel that while this is necessary it is almost more important to ensure that other upward transmission mechanisms for staff to report concerns need to be in place so that issues don't have to escalate to a 'whistle blower' stage. What actions are you taking here?

e) When things go wrong do you carry out root-cause analyses and how do you balance ascribing responsibility to an individual versus the system and do you feel you get this right?

f) Which other trusts do you compare yourself to and how? How much is your performance management focussed on driving out poor performance and aiming high, rather than merely achieving some small improvements, which can then be reported as progress?

g) How does a retrospective document such as a Quality Accounts link to your future strategy for the Trust and where are these links examined?

h) Are there patients in your hospital today who could be somewhere else and what are you doing with partners to improve the quality of care after discharge?

i) The Patient Reported Outcome Measures (PROM) (page 29) isn't very effective as response rates are low. What can be done to increase response rates such that this data can be statistically significant and so of some use?

j) What, steps, if any, is the Trust taking to assess the quality of services provided with the same degree of rigour that is applied to assessing cost and accounting for the Trust's budget?

k) How much data analysis does the Trust carry out by geographic community? For example, what could you tell us about the use of the Homerton by residents who live in the City of London and their satisfaction with services? As there is now a separate Health and Wellbeing Board for the City are you making any plans to further disaggregate the data you collect between Hackney and other local authority areas or even between different geographic areas of Hackney?

We look forward to receiving a written response and if necessary we can take up any outstanding issues when the Homerton presents its next regular update to the Commission.

Yours sincerely

Councillor Luke Akehurst
Chair of Health in Hackney Scrutiny Commission

cc Common Councilman Vivienne Littlechild, Corporation of London
Common Councilman Wendy Mead, Corporation of London
Neal Hounsell, Corporation of London
Tracey Fletcher, Chief Executive, Homerton
Charlie Sheldon, Chief Nurse and Director of Governance, Homerton

Committee:	Date(s):
Health and Social Care Scrutiny	16th July 2013
Subject: Bart's Health Trust Quality Accounts Update	**Public**
Report of: Director of Community and Children's Services	**For Information**

Summary

This report sets out the approach the Corporation has taken to scrutinising the Bart's Health Trust Quality Accounts as part of the Inner North East London Joint Overview and Scrutiny Committee for Health (INEL JOSC).

Recommendations

Members are asked to:

- Endorse the approach taken to scrutinising the Homerton University Hospital Quality Accounts.
- Note the written submission to the Barts' Health Trust Quality Accounts from the Chair of the INEL JOSC (Appendix B to this report).

Main Report

Background

1. All NHS Hospitals are required to produce annual quality accounts setting out their approach to all aspects of hospital services. Scrutiny Committees from any geographic area served by a hospital have an opportunity to make comments and raise issues about the accounts. These are included within the final documents submitted to the Department of Health.

Current Position

2. As the Bart's Health Trust covers such a wide number of hospitals and areas in London Officers proposed that the Inner North East London Joint Overview and Scrutiny Committee for Health (INEL JOSC) was convened to scrutinise the accounts and question the senior management of the Trust.
3. The meeting of the INEL JOSC and the Trust took place on Wednesday 29th May and the minutes of the meeting are attached to this report as Appendix A. As the City of London Corporation representative (CC Vivienne Littlechild) was unable to attend the meeting Common Councilman Wendy Mead (as the only elected Member of the 2013/14 Health Scrutiny Committee at that time) was asked to replace her for this meeting.

4. As the minutes show the meeting covered a wide range of issues and a number of amendments and additions were made to the final quality accounts submitted by the Trust as a result.

5. Following the meeting a formal letter from the Chair of the INEL JOSC was sent to the Trust setting out the key points from the meeting. This is attached as Appendix B to the report. The letter can be used by scrutiny committees during the course of the year to monitor the ongoing performance of the Bart's Health Trust.

Appendices

- Appendix A – Minutes of the INEL JOSC meeting 29th May 2013.
- Appendix B – Letter from the Chair of INEL JOSC to the Chief Executive of the Bart's Health Trust.

Neal Hounsell
Assistant Director Commissioning and Partnerships
T: 0207 332 1638
E: neal.hounsell@cityoflondon.gov.uk

APPENDIX A

MINUTES OF A MEETING OF THE INNER NORTH EAST LONDON JOINT OVERVIEW AND SCRUTINY COMMITTEE FOR HEALTH

WEDNESDAY, 29TH MAY 2013 AT 7.00 PM
OLD TOWN HALL, STRATFORD

Members Present:	**Councillor Winston Vaughan (Chair), Councillor Luke Akehurst (Vice Chair), Common Councilman Wendy Mead, Councillor Ann Munn, Councillor Lesley Pavitt and Councillor Ted Sparrowhawk**
Member Apologies:	**Councillor Terence Paul, Councillor Dr Emma Jones, Cllr Rachel Saunders**
Officers in Attendance:	**Tahir Alam (Strategy Policy and Performance Officer, LB Tower Hamlets), Hafsha Ali (Head of Scrutiny, LB Newham), Sarah Barr (Senior Strategy, Policy and Performance Officer, LB Tower Hamlets), Luke Byron-Davies (Scrutiny Manager, LB Newham and Jarlath O'Connell (Overview and Scrutiny Officer, LB Hackney)**
Also in Attendance:	**Judith Bottriell (Head of Governance Standards and Risk Management, Barts Health NHS Trust), Councillor Leanora Cameron (LB Newham), Dr Clare Dollery (Deputy Medical Director, Barts Health NHS Trust), Mark Graver (Head of Stakeholder Relations and Engagement (Barts Health NHS Trust), Councillor Wendy Mitchell (LB Hackney), Peter Morris (Chief Executive, Barts Health NHS Trust), Councillor Nicholas Russell (LB Waltham Forest) and Michael Vidal (Hackney resident)**

1 Welcome and Introductions

1.1 The Chair welcomed everyone to the meeting and stated it had been convened to jointly consider the draft Quality Accounts for Barts Health NHS Trust. This was the first year this matter had been considered by the JHOSC as it had been agreed amongst Members that because activities of the newly merged Trust crossed the four borough boundaries as well as neighbouring Waltham Forest, that it would be appropriate to consider the Quality Accounts jointly.

2 Membership of the Committee

2.1 The Committee noted the updated Membership list for Inner North East London Joint Health Overview and Scrutiny Committee. It was noted that Common Councilman Mead had replaced Common Councilman Littlechild from the City of London.

3 Apologies for Absence

3.1 Apologies for absence were received from Cllrs Saunders and Jones from Tower Hamlets and Cllr Paul from Newham.

3.2 An apology for absence was also received from Cllr Hayhurst, a member of Health in Hackney Scrutiny Commission.

3.3 The Chair stated that he had received an apology also from Cllr Khevyn Limbajee, the Chair of Waltham Forest Council's Health Scrutiny Committee who had been invited to attend as an observer.

4 Minutes of the previous meeting

5.1 The Committee gave consideration to the minutes of the meeting held on 30 April 2013.

RESOLVED:	**The minutes of the meeting of the Committee held on 30 April 2013 were agreed as a correct record subject to the following amendment:** **- top of page 4 - the 'Q' and 'A' indicating 'question' and 'answer' were in the wrong order for the first two questions.**

5 Declarations of Interest

4.1 There were none.

6 Actions and matters arising from the meeting on 30 April 2013

6.1 The Chair reported that following the previous meeting of INEL JHOSC on 30 April on London Cancer's case for change on the provision of urological cancer services, he had written to NHS North and East London Commissioning Support Unit summarising the key points from the meeting and suggesting that the NHS officers come back to the Committee in six months on the actions they would be taking in particular to mitigate the transport issues. It was suggested that as Outer North East London's JHOSC (ONEL JHOSC) had similar issues that a briefing to both committees meeting jointly in Oct-Nov would be best. Officers would liaise with their counterparts in ONEL JHOSC to set this up with the London Cancer representatives and INEL Members would be informed.

ACTION:	**INEL support officer to liaise with ONEL officer on a date on which to invite London Cancer and NHS NEL CSU back to provide an update on the implementation of the urological cancer service changes.**

7 Barts Health Trust Quality Accounts 2012/13

7.1 The Chair welcomed the following senior officers from Barts Health NHS Trust to the meeting:

Mr Peter Morris, Chief Executive
Dr Clare Dollery, Deputy Medical Director
Judith Bottriell, Head of Governance Standards and Risk Management
Mark Graver, Head of Stakeholder Relations and Engagement

and Members gave consideration to the Barts Health NHS Trust Draft *Quality Accounts for the period 1 April 2012 to 31 March 2013*.

7.2 In introducing the Quality Accounts Mr Morris stated that the newly merged Trust was entering its second year and in the first six months it had successfully collapsed the governance arrangement for the three legacy Trusts and created a single governance structure across the new organisation. Six new Clinical Advisory Groups had been created across the organisation with advanced leadership in place. They had taken down the site based arrangements and replaced them with the new structure. Quick progress had been made in the first year with 38 new clinical directors and 5 clinical service lines set up across the organisation and he suggested that the new organisation had now turned a corner and they could be satisfied with the level of progress made in just one year.

7.3 There were two areas of under-performance - on A&E and on Urgent Care and they had channelled activity towards addressing these. In terms of finances, the Trust would end the year with a small surplus (subject to audit) and this was an achievement considering that the consolidation of three trusts into one had represented the biggest NHS merger in the country.

7.4 In terms of priorities for the coming year they needed to attend to the long term financial stability of the Trust. Progress in the second year would be extremely challenging with c. 4% of non recurrent funding to be made up and the need to wean the organisation off this element of funding and put it on a more secure footing. This would create a steep uphill curve for the organisation in its aims to achieve financial balance. In the first quarter there had been a 50% increase in the savings target for example so a period of catching up would be necessary. Post the Francis Report there was a lot of work to be done around the issues of values and behaviours and the kind of culture the Trust needed to engender. The Trust was also having to handle important changes on the London scene with significant changes on the provision of services for cardiovascular disease, cancer and intensive care coming downstream. The Trust was submitting bids on provision of lung and gastric cancer surgery in a reconfigured system and they were applying for Out of Hours surgery provision in Newham. He concluded that the Board was functioning well and the organisation now had to create the right relationships and not act as an independent entity doing its own thing.

Questions and answers

7.5 **<u>The Chair opened the questioning by asking the officers if they could outline what in their view are the three best and the three worst performing areas in the Trust.</u>**

7.6 Ms Bottriell replied that in terms of the standard national surveys the Trust had been performing consistently well. They had performed well on the amount of shared sleeping areas and bathroom and shower facilities. They also performed well on communications with GPs and on the sharing of referral letters. In terms of areas which needed improvement - food service and nutrition required more attention with less patients satisfied with the quality of food and not getting sufficient help with feeding and the CQC had picked up on this in their inspection of Mile End Hospital. To respond to this they had put in place an Older Peoples Improvement Programme and nutrition was a key part of that. There had been some disappointing results also on clinical teams and around nursing but a lot was being done to improve these systems.

7.7 Mr Morris added that the Trust needed to rapidly improve on its handling of complaints and on the connections between Complaints and the local management teams. They also had to improve the administration of the appointment bookings system and on the issue of making people feel that Barts was a caring organisation. They had had excellent performance reports and the areas where there was room for improvement outlined by the CQC were taken very seriously. He stated he was encouraged this year that the levels of activity from the CQC. The Trust received regular external assurance and it needed to be pointed out the CQC had had no major concerns.

7.8 **<u>Cllr Pavitt described the experience of a friend in the Royal London who had received no assistance with feeding and food had been left on trays five days running. The senior managements attention to these issues did not seem to be filtering down to the Health Care Assistance and she was concerned that the report did not make clear how the performance issues which were being raised were disseminated down to the wards.</u>**

7.9 Ms Bottriell replied that this was an important point. The issue with the Quality Accounts Report however was that a high level overview was required but she agreed that Health Care Assistants and Matrons were vital in implementing these actions. On this specific point: trays had to be checked more frequently and these issues should also be brought up at Clinical Fridays, where all senior managers in the hospitals go “back to the floor”. Nutrition was audited as part of a rolling programme so they understood which wards were not doing well.

7.10 **<u>With reference to p.45 of the accounts and the NHS National In-patient Survey Results , Cllr Munn asked whose expectation was this?</u>**

7.11 Ms Bottriell replied that it was the Commission for Quality Improvement Scheme CQIN and this was a national Department of Health improvement area. Statistically it was a crude measure but they had to report on it she added.

7.12 **<u>Cllr Munn commented that the problem with this diagram was that it was difficult to work out where Barts stood and where it needed to get to.</u>**

7.13 Mr Bottriell agreed that there needed to be a baseline added to this chart and targets had to be set individually. It was demonstrating a 5% improvement but she agreed that this chart needed to be made easier to understand.

7.14 Cllr Akehurst stated in relation to the Patient Experience CQUIN results on page 45 that if these figures were reversed they would be quite frightening i.e. more than half those surveyed did not find someone on the hospital staff to talk to about their worries and fears. Also, nearly 60% stated that a member of staff had not told them about the side effects of their medication and what to watch out for when they went home. He asked what was being done to address these. These indicators were very important he added because they shaped the patients perception of the hospital in a profound way.

7.15 Ms Bottriell replied that they ensured that every patient was treated with empathy. She cautioned that this particular survey had had a small sample size of less than 300 people. These indicators were measured more widely and a one-off survey once a year should not be relied on on its own. Dr Dollery added that they had also initiated a Discharge Booklet for patients.

7.16 Cllr Mitchell asked whether there were other sources of data that the Committee should be aware of if this survey had a small sample size and was therefore not sufficiently reliable.

7.17 Mr Morris explained that these small surveys were run to test the temperature as it were in certain specific areas but that more broadly there are a wide variety of different methods used to collect patients views. Ms Bottriell added that they would start to standardise the data here and improve the matrices used. They had focused in this part of the report on a high level survey but also added some local data as well. Mr Morris added that what was important was the degree of leadership provided, the prevailing climate and the ensuring that the organisations values were about listening and acting on concerns raised. They were doing some work on leadership and specifically on the leadership at ward level and a key focus was getting feedback and ensuring issues were acted on.

7.18 Cllr Sparrowhawk raised a concern about people he knew who had received appointments at three different Barts Trust hospitals on the same day and asked what was being done to sort this out. Transport remained a key problem for the elderly and the vulnerable he added.

7.19 Cllr Pavitt took issue with the rules about carers attending appointments and stated that in cases where elderly people had memory loss or dementia it was critical that they had their carer with them at all times.

7.20 Mr Morris replied that Barts did not excel on out-patients experience and in particular on bookings, appointments and the issuing of appointment letters. This problem was compounded by having three different information systems across the three legacy Trusts and it would be corrected carefully over the next few years. On the issue of transport there was a more positive story to tell and improvements were being made.

7.21 **With reference to the chart on the number of serious incidents, Cllr Russell (Health Scrutiny Member from Waltham Forest Council) asked what was being done to address the high number of incidents in Whipps Cross Hospital. In addition he asked what work was being done on the treatment of learning disabled and learning disabled children and their carers. Finally, he stated that prior to the merger Whipps Cross had had a Disabled Patients Forum but this had been disbanded and he asked if this could be re-instated.**

7.22 Dr Dollery replied that a lot of effort was being put into addressing the important issue of serious incidents with a clear focus being put on prevention. If systems were in place early enough there would be a significant reduction in these. In relation to patient representatives there would be a patient representative on all the Clinical Academic Groups (CAGs) but not all had been recruited yet. In relation to the group at Whipps Cross she stated that it was of course important to learn from the patient involvement arrangements at Whipps Cross and they would look to re-instate the Disability Consultative Group. Mr Morris thanked Cllr Russell for these detailed questions and undertook to take these issues back.

7.23 **Cllr Sparrowhawk asked how the hospital would go about choosing the patient representative on the Disabled Patients Group. He commented that many patient representatives were self selecting and did not provide enough challenge.**

7.24 Dr Dollery replied that all the new CAGs were in the process of recruiting people

7.25 **With reference to the serious incidents chart on page 29, Cllr Pavitt stated that it was difficult to read the comparisons in the chart as it needed more information on scale and the rate of incidents per day.**

7.26 Ms Bottriell replied that if you looked at the complexity of the patient pathway it was difficult to present this information simply. For example a trauma department will have a higher risk of incidents so it is difficult to compare and there are also other factors at play. The numbers of serious incidents tell you very little e.g serious incidents in maternity wards are represented as SI's yet these are a natural consequence. It was important to understand that there were a number of factors at play.

7.27 **Cllr Munn stated that a lot of context was missing from these charts and that a more accurate description of the situation being described would have been preferable.**

7.28 Mr Morris replied that Barts Health Trust did need to look more closely at how to represent the differences of scale in the charts presented.

7.29 **Cllr Munn asked what has the impact of the merger been on staff from hospital ward level upwards**.

7.30 Dr Dollery replied that there were stresses involved but there was an extensive programme of briefings going on and senor staff were going out into the wards.

Progress was being made on the quality of staff appraisals and they had also introduced for example a 'Barts Heroes' award for staff.

7.31 <u>Cllr Munn asked if the staff could easily raise issues on an ad hoc basis and how can you measure the effectiveness of this.</u>

7.32 Mr Morris commented that the best way for senior management find out about issues by simply asking people questions. It is important then to move on issues locally. The Trust was routinely surveying 2000 people within the organisation each month. He stated that every Friday he was out on the wards and the non-exec Board members were also frequently seen on walkabouts. One of the issues he picked up for example was the perception at Whipps Cross that decisions seemed to be taken elsewhere. A lot of listening goes on and it was also interesting he added that the issues which most occupy staff were not the merger per se but issues of perhaps a more prosaic nature such as it taking longer to organise a recruitment panel or to replace a tv set in a ward. Ms Bottriell added that each site had a Professional Nurse Lead so that staff would always have access to her and there was still local ownership of issues. Mr Morris added that staff capacity had improved greatly for example one year previously Whipps Cross had 3 consultants and 1 locum in post and now they had 8 and this was in part because of the benefit of the Barts Health brand.

7.33 **<u>Cllr Sparrowhawk followed on from Mr Morris' comments on Friday walkabouts that it was mentioned in the news that the weekend was the worst time to have an operation, considering the reduced staffing available in hospitals at weekends</u>**

7.34 Mr Morris commented that the Trust should be operating 24/7 but they did have systems in place to ensure that proper care was provided during off-peak times

7.35 <u>Cllr Sparrowhawk asked how the Barts structure encouraged a culture of feedback to ensure that any poor practice was identified at an early stage.</u>

7.36 Mr Morris replied that staff were continually reminded of their professional obligations to report any shortcomings. He added that the Trust had a robust process of risk assessment in place and they were paying particular attention to ensure that staff could always report issues. The key message to staff was "when in doubt escalate".

7.37 <u>Cllr Pavitt again expressed concern that these messages didn't get through to ward staff. She detailed a case of an individual who for medical reasons needed three pillows instead of one and yet it had been difficult to even get this escalated.</u>

7.38 Ms Bottriell commented that in the light of the Francis Inquiry it was important that that situation was not replicated where everybody knew about the problems but nobody took ownership.

7.39 <u>Common Councilman Mead stated that the Committee had just been through a scrutiny of the changes to urological cancer services and had asked a number of searching questions. She asked why Barts Health had missed out on its two bids to take on these consolidated services.</u>

7.40 Mr Morris clarified that they hadn't put in for bladder and prostate cancer surgery but had contested for renal and had missed out on a good bid made by the Royal Free Hospital. There were a number of bidding opportunities in the pipeline and they intended to bid for oesophagus, stomach and lung cancer surgery. They would be competing with UCH on these tumour groups and they were working to put the best possible service forward. Outside of cancer, they were also bidding for future opportunities relating to thoracic and chest surgery.

7.41 <u>Cllr Akehurst asked (a) how had the merger facilitated the principle of "localise where possible, centralise where necessary" (b) what was the Trust doing to mitigate against the lessons learned from other large hospital mergers and (c) the Quality Accounts were historical but how would this evidence base be used to make sure that the needs of the population were being met.</u>

7.42 In relation to (a) Mr Morris replied that this principle was firmly embedded in the approach of the CAGs in formulating their strategies. There was an element of both at play. Some provision had moved out of teaching hospitals and some had moved in. They needed to be evidencing both the quality improvements and economic gains to be had from centralising. He added that one area being explored to override geographical considerations was the use of Skype clinics when they were appropriate. Newham for example had 85% broadband coverage and this area had potential.

7.43 In relation to (b) he stated that some large mergers had been a success: Sheffield, Newcastle, Central Manchester but in other mergers many trusts had got very lost in the first two years. They learned the lessons from the South London Trust who had taken an extraordinary amount of time to even get their new Board in place. They key elements were Leadership, Culture and Engagement and the Trust had got a clear strategy in place and alignment of activity both inside and outside the trust. They learned much from the Sheffield, Greater Manchester and in London the Imperial mergers. Dr Dollery added that they had secured specialist advice from experts and Imperial had sent over their patient safety people to oversee their changeover plans. Ms Bottriell added that on centralisation they had worked hard on a due diligence approach and they had known that processes had to be embedded quickly. They had quickly engaged with the CQC and they had got a centralised team in place quickly so they were ready to go on Day One. Mr Morris added that they had learned from other mergers how quickly other system degraded after day one if the organisation was not in strong position to begin with. The difficulties around integrating information did have an impact on the frontline and they would pay rather more attention to back office integration.

7.44 <u>In relation to CQC inspections the Chair asked why they only mentioned certain outcomes and how many outcomes would the CQC look at. The report listed 4 for Newham and 6 or 7 for Mile End.</u>

7.45 Mr Morris replied that they were not chosen by the Trust they were chosen by the CQC. The CQC does unannounced inspections and generally look at 4 or 5 outcomes, they just turn up and arrive on a ward so the first person they might see could be a Healthcare Support Worker. There had been a complete change in how the CQC carried out inspections and how the Trust reacted to

them and it was impossible to prepare staff. The CQC met doctors, nurses and patients and what they fed back was what they found on that day. It was important to note however that they had never had any grave concerns arising from any of their visits to the Trust's sites.

7.46 <u>The Chair stated that Barts was 9th in the country on the Standard Mortality Indicator but it was also now the largest trust and suggested therefore that being 9th wasn't good enough.</u>

7.47 Dr Dollery replied that it was her aspiration of course to get to no. 1. In relation to Cllr Akehurst's question (c) Ms Bottriell added that the Trust has clearly indicated where there were shortcomings and they knew the areas where they needed to improve. Using better integrated data systems and better performance data systems would help and an example of this was the new 'Integrated Performance Dashboard' which tracked all areas of poor performance in a consistent fashion. The Quality Assurance Sub Committee of the Board has identified 6 quality priorities and would track the progress of all these closely in the year ahead.

7.48 <u>Cllr Russell asked if senior staff on the 'back to the floor' walkabout days also visited outpatients departments.</u>

7.49 Mr Morris replied that they did.

7.50 <u>Cllr Russell asked what was being done to improve transfer of care and in particular what was being done to assist patients who may have psychological crises.</u>

7.51 Mr Morris replied that the issue of how to manage care closer to home was a very big topic for the Trust now. They also had a good relationship with the local Mental Health trusts in each area and had agreed to prioritise this issue at a board level conversation between the Trusts and they would be pleased to come back with more specifics on this following that meeting. Mr Graver added that in the three emergency departments they ran they reviewed patient cases and attendances and in particular at the issue of patients arriving at A&E who might have mental health support needs. Work was ongoing with the ELFT and NELFT (the relevant mental health trusts) on this. Mr Morris added that there was a System Group set up on integrated care and it would be good to have a collective account of this.

7.52 <u>Mr Vidal, a Hackney resident, asked in relation to CQC outcome 13 and 14 in the board papers and the specific reference to the point that the Trust was 15% under its staff complement.</u>

7.53 Mr Morris replied that they were far too reliant on bank and agency nurses and doctors in certain areas and they certainly aimed to employ more permanent staff and he wished to give this a higher priority. Dr Dollery added that the challenge if you had agency staff was that they often didn't have computer log-ins quickly enough and so they were not able to immediately function at the highest level required consistent with modern medical practice.

7.54 The Chair summed up by stating that he had found many good things in the Report and it was good to see positive signs of improvement. The report had

been written in business language and so at times it had been difficult to decipher and this should be attended to. There were some areas where they would provide some additional feedback he added.

7.55 Mr Graver stated that because of the Department of Health deadlines they were subject to on this they would need the response letter from the Chair by 5 June for submission with the Quality Accounts. It was noted that the minutes of this meeting would also be submitted in due course.

7.56 The Chair replied that this could be done but where there were outstanding issues which Members wanted to go into in more detail, then this would best be achieved in the individual Health Scrutiny Committees.

7.57 The Chair thanked Mr Morris and the officers for taking the time to attend and answer the Members' questions.

RESOLVED	**That the draft Quality Accounts and the discussion be noted.**

ACTION:	**Chair to submit to Barts Health NHS Trust by 5 June a formal response from the Committee on the Quality Accounts.**

8 Any other business

8.1 There was none.

Duration of the meeting: 7.00 - 9.00 pm

Signed

……..

Chair of Committee

Contact:
Jarlath O'Connell
020 8356 3309
jarlath.oconnell@hackney.gov.uk

APPENDIX B

Cllr Winston Vaughan
Chair, INEL JHOSC
c/o Jarlath O'Connell
Hackney Council
Overview & Scrutiny Team
Hackney Service Centre, 2nd Floor
1 Hillman St
London E8 1DA

5 June 2013

Mr Peter Morris
Chief Executive
Barts Health NHS Trust
Aneurin Bevan House
81 Commercial Road
London E1 1RD

Dear Mr Morris

Barts Health Trust Quality Accounts 2012-13

Thank you for attending the meeting of the Inner North East London Joint Health Overview and Scrutiny Committee on 29 May on the subject of Barts Health Trust's Draft Quality Accounts for 2012-13.

This is the first year that our four authorities have considered your Quality Accounts as a Joint Committee and we hope you found it a productive way to deal with this issue, considering that the newly formed Trust's activities now cross all our boundaries as well as our neighbouring borough of Waltham Forest.

After considering your report we decided to focus the discussion at the meeting on three distinct areas: Patient Experience, Governance and Strategy and Future Plans.

During our discussions the following key points were noted:

Specific areas of concern

a) The Merger
The size and complexity of the merger was clearly significant and it was encouraging to see, in the majority of areas, how much progress had been made in the first year and indeed the degree of stability maintained. This is particularly in light of the immensity of this challenge of collapsing the governance arrangements across six

hospitals and creating a single new governance model with six Clinical Academic Groups (CAGs) being put in place.

b) Underperformance in general

Where there are areas of underperformance, the Committee was also, in the majority of cases, pleased to see these acknowledged and mitigation plans put in place. We note that the introduction of the Integrated Performance Dashboard that will track the progress made on your six quality priorities over the coming year and we will be interested to monitor these.

c) IT integration issues

The Committee was concerned to hear about the problems you encountered in planning a newly integrated IT system resulting from the merger and that this is still causing distress to patients and problems for employees of the Trust. It is acknowledged that this will take a considerable time to rectify and the Committee would like to see some tangible progress on this as soon as possible.

d) Complaints

We welcome your commitment to take action on specific areas such as complaints handling, administration of and booking of patient appointments and the need to make patients feel that Barts Health Trust is an organisation which cares and puts patients' needs first.

We would however also like to see progress on the concerns raised by the Care Quality Commission relating to the quality of the food service and nutrition following their recent inspection at Mile End Hospital and Newham University Hospital. We view this as an issue that should be given priority across all your sites.

e) Disability Consultative Group

We were pleased that you have undertaken to give further consideration to the possibility of re-instating the Disability Consultative Group at Whipps Cross Hospital however we note that you are in the process of putting new consultative structures in place and embedding them within the CAGs.

f) Staffing Rates

We share your concerns about the over reliance on 'bank' and agency clinicians and we support your efforts to reduce this. We noted that staff cannot function at a high level unless they have full access to IT systems and this can be challenging with high turnovers.

g) Integrated Care

We share concern about the need to progress integrated care for those presenting at emergency services who may also have learning disabilities or mental health support needs and would encourage you to work closely with both NELFT and ELFT on tackling this issue.

h) The Quality Accounts Document

In relation to how information is presented within the report, the Committee had some concerns that appropriate baselines needed to be added to the charts and graphs so that meaningful comparisons can be made. Without this information it was in some cases impossible to scrutinise the differences of scale and trends.

We also had concerns that some data presented were 'micro' surveys with small sample sizes and it was not sufficiently explained that these needed to be weighted against results from larger surveys. In future, Accounts, if the sample size you are presenting to us is small and not statistically significant, we would suggest that, where there are other sources of data on an issue, we should be made aware of these in order to give us a fuller picture.

We would ask that greater attention is given to balancing the presentation of matrices from large surveys with small local surveys and that this presented more explicitly in your narrative.

We are grateful to you and your senior officers for your constructive engagement with our Committee's work and your commitment to having an open discussion about the issues we raised.

The minutes of our meeting on 29 May will be sent to you shortly.

Yours sincerely

Cllr Winston Vaughan
Chair, Inner North East London Joint Health Overview and Scrutiny Committee

cc All INEL JHOSC Members
Cllr Khevyn Limbajee, Chair Of Waltham Forest Health Scrutiny Committee
Cllr Nicholas Russell, Member Waltham Forest Health Scrutiny Committee

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