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

Date: TUESDAY, 5 MAY 2015

Time: 1.45 pm

Venue: COMMITTEE ROOMS, WEST WING, GUILDHALL

Members:
Wendy Mead (Chairman)
Dhruv Patel (Deputy Chairman)
Judith Pleasance
Emma Price
Ann Holmes
Adam Richardson
Tom Sleigh
Philip Woodhouse
Steve Stevenson (Healthwatch)

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Lunch will be served in the Guildhall Club at 1pm
NB: Part of this meeting could be the subject of audio or video recording

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 agree the public minutes and non-public summary of the meeting held on 2 February 2015.

   (Pages 1 - 4)

4. **INEL JHOSC MINUTES**
   Minutes of the meeting held on 12 February 2015.

   For Decision
   (Pages 5 - 12)

5. **BARTS HEALTH VERBAL UPDATE**
   Verbal report of the Director of Community & Children's Services.

   For Information

6. **PRIMARY MEDICAL SERVICES FROM PORTSOKEN SITE**
   Report of NHS England.

   For Information
   (Pages 13 - 14)

7. **HEALTHWATCH CITY OF LONDON UPDATE**
   Report of Healthwatch City of London.

   For Information
   (Pages 15 - 18)

8. **REVIEW OF HEALTH OVERVIEW AND SCRUTINY FUNCTIONS**
   Report of the Director of Community & Children's Services.

   For Decision
   (Pages 19 - 38)

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

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

HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY AND CHILDREN'S SERVICES) COMMITTEE
Monday, 2 February 2015

Minutes of the meeting of the Health and Social Care Scrutiny Sub (Community and Children's Services) Committee held at Committee Rooms, West Wing, Guildhall on Monday, 2 February 2015 at 11.00 am

Present

Members:
Wendy Mead (Chairman)
Dhruv Patel (Deputy Chairman)
Ann Holmes
Emma Price
Tom Sleigh
Steve Stevenson (Healthwatch City of London)

Officers:

Philippa Sewell	Town Clerk's Department
Neal Hounsell	Community & Children's Services
Nina Bhakri	Community & Children's Services
Simon Cribbens	Community & Children's Services

In Attendance:

Malcolm Alexander	Patients' Forum for the London Ambulance Service
Chris Hartley Sharpe	Senior Manager London Ambulance Service
Victoria Holt	CHUHSE clinical lead
Ben Lee	Shared Intelligence
Ryan Ocampo	CCG Urgent Care Programme Manager
Haren Patel	CCG Vice Chair

1. **APOLOGIES**
   Apologies were received from Judith Pleasance, Adam Richardson and Philip Woodhouse.

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
   The Deputy Chairman Dhruv Patel declared a non-pecuniary interest in item 6 by virtue of his family's pharmacy business within the City and Hackney CCG, and in item 10 by virtue of the CCG Vice Chair being a family friend.

3. **MINUTES**
   RESOLVED – That the public minutes and non-public summary of the meeting held on 25 November 2014 be agreed as a correct record, subject to the correction of a typo.

Matters Arising

Community Nursing Services

The Assistant Director, Partnerships and Commissioning advised that Dr Vasserman had replied to say he was happy with the changes currently, but would contact the Sub Committee should any issues arise.

4. **CO-OPTED HEALTHWATCH MEMBERS**

RESOLVED – that Steve Stevenson be co-opted in the place of David Simpson as a representative for Healthwatch.

5. **HEALTHWATCH CITY OF LONDON UPDATE**

The Sub Committee received a report from Steve Stevenson from Healthwatch. Members discussed the qualitative data gathered by Healthwatch, and requested Officers work with the organisation to share quantitative data wherever possible and appropriate. Members noted that the administrative issues with Barts Trust were being pursued by the Inner North East London Joint Overview and Scrutiny Committee, who were meeting on 12 February 2015.

RESOLVED – That Officers work with Healthwatch to share quantitative data wherever possible and appropriate, and that the report be noted.

6. **DEFIBRILLATORS IN PHARMACIES**

The Chairman welcomed Malcolm Alexander from the Patients' Forum for the London Ambulance Service (LAS) and Chris Hartley Sharpe from the LAS.

Mr Alexander reported that the LAS Patients' Forum was supporting the LAS campaign to encourage every pharmacy in London to install a defibrillator and ensure that staff are trained in their use. Mr Hartley Sharpe advised the Sub Committee that where there is a defibrillator and someone trained to use it within a short time frame, the chance of survival from cardiac arrest can increase from approximately 28% to 80%. He also advised Members that LAS had set up an accreditation scheme to ensure effective use and management of defibrillators. The accreditation scheme also registered the defibrillators so that LAS are aware of its location, and can alert the holder in the event of an emergency in the vicinity. The accreditation would last for two years to ensure defibrillator users received regular training. LAS were developing a database of existing defibrillators, though, as it was compiled reactively, Members noted this would not be a comprehensive list. Members also noted that the LAS and the Patient's Forum would like to see every City of London pharmacy hold a defibrillator registered on its accreditation scheme.

Members discussed the project in detail, including the need for government guidance and support, and queried how the LAS's scheme was being promoted nationally. Mr Hartley Sharpe advised that he was promoting this work with LAS's across the country, some of which were adopting similar projects. Members agreed to write to Mark Field, MP for the City, to seek support to promote the holding of defibrillators in pharmacies and the LAS accreditation scheme. The Sub Committee queried about training in schools, and Mr Hartley Sharpe reported that CPR training in schools was not compulsory in the UK,

but the LAS collaborated with Saving Londoners Lives to train teachers and provide them with the equipment to train others.

RESOLVED – That:

(a) A letter be sent to Mark Field MP regarding the need for statutory defibrillator guidance from the government, and seeking support to promote the holding of defibrillators in pharmacies and their accreditation through the LAS scheme;
(b) To use the City's Business Healthy network to promote the scheme to businesses in the City;
(c) A recommendation be made to the Health and Wellbeing Board to undertake a survey of which premises in the City had defibrillators on site; and
(d) The report be noted.

7. **REVIEW OF HEALTH OVERVIEW AND SCRUTINY FUNCTIONS**

The Sub Committee considered a report of the Director of Community & Children's Services regarding the opportunity to examine whether there were any areas where the Sub Committee's health overview and scrutiny functions could be enhanced. Members had a detailed discussion as to the Health and Social Care Scrutiny function in the City, and the following points were noted for development:

- How the Sub Committee is alerted of complaints/issues to review;
- The need to publicise the existence of the Sub Committee;
- The need to clarify the difference between the Sub Committee, Health and Wellbeing Board and Inner North East London Joint Overview and Scrutiny Committee;
- Who is within the Sub Committee's purview to scrutinise;
- The need to review the Sub Committee's relationship with Health and Social Care providers/commissioners, partner organisations and co-opted groups;
- User experience is key – what information and data to ask for and how is it obtained;
- How to be both proactive with scrutiny work and reactive to issues that arise;
- Membership of Sub Committee.

RESOLVED – That:

(a) The structure and framework for the two phased review presented within this report be approved;
(b) A working group be established, comprising of Emma Price and Wendy Mead, to work with officers to incorporate analysis, conclusions and recommendations into a report to be presented to the Health and Social Care Scrutiny Sub Committee in May 2015; and
(c) The report be noted.

8. **OVERVIEW OF THE OUT OF HOURS SERVICE IN CITY AND HACKNEY FOLLOWING ONE YEAR OF OPERATION**

The Chairman welcomed Dr Victoria Holt (Clinical Lead, CHUHSE), Dr Haren Patel (CCG Board Member and Clinical Lead for Out of Hours) and Ryan Ocampo (Programme Manager – Urgent Care, CCG) to the meeting.

Dr Patel and Dr Holt took Members through the report, noting that there had been a robust procurement process and that close contract monitoring was in place. CHUHSE had been awarded the contract and began its service in December 2013. Dr Holt advised that CHUHSE was completing more calls on the phone, visiting fewer patients, and recommending fewer visits to urgent care centres than its predecessor had, thus indicating a more efficient service and ensuring patients were not unnecessarily attending A&E. In response to Members' questions, Dr Holt commented that the initial hurdle faced by the service had been problems with the call handling service; this had initially had been subcontracted to the provider of the local 111 service but had been brought in house since September 2014. Dr Holt also advised Members of an overnight nursing service being put in place; this was in early stages but would be available seven days a week once up and running and would ensure a high standard of palliative care.

RESOLVED – That the report be noted.

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 was no other business.

The meeting ended at 1.00 pm

Chairman

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

THURSDAY, 12 FEBRUARY 2015

Meeting held at 7.00 pm at Room 3, Assembly Hall, Hackney Town Hall, Mare St, London E8 1EA

Committee Members Present:	**Cllr Ann Munn (Chair), Cllr Dianne Walls OBE (Vice Chair), Cllr Mahbub Alam, Cllr David Edgar, Cllr Ben Hayhurst, Common Councilman Wendy Mead, Cllr Rosemary Sales and Cllr Winston Vaughan**
Member apologies:	**Cllr Asma Begum and Cllr Anthony McAlmont** Other apologies from Cllr Emmerson (Waltham Forest), Common Councilman Dhruv Patel (City of London Corporation) and Terry Huff (Chief Officer, Waltham Forest CCG).
Officers in Attendance:	**Tahir Alam (Strategy, Policy and Performance Officer, Tower Hamlets), Nina Bhakri (Policy Officer, City of London Corporation) and Jarlath O'Connell (Overview and Scrutiny Officer, Hackney)**
Also in Attendance:	**Dr Sam Everington (Chair, Tower Hamlets CCG), Dr Steve Ryan (Medical Director, Barts Health NHS Trust), M Neil Kennett-Brown (Transformation Director – Newham, Tower Hamlets and Waltham Forest CCGs), Dr Zuhair Zarifa (Chair, Newham CCG), Deborah Kelly (Deputy Chief Nurse – Patient Care and Experience, Barts Health NHS Trust), Mr Steve Millington (Consultant Orthopaedic Surgeon, Barts Health NHS Trust), Jo Carter (Stakeholder Relations Manager, Barts Health NHS Trust), Satbinder Sanghera (Director of Partnerships and Governance, Newham CCG), Don Neame (Director of Communications NHS NE London Commissioning Support Unit), Claire Lynch (Communications Manager, Transforming Services Together, NHS NEL CSU)**

1. WELCOME AND INTRODUCTIONS

1.1 The Chair welcomed everyone and introductions were made. There were no Substitute Members.

1.2 The Chair stated that Cllrs Emmerson and Sweden, the Chairs of the Health and Adult Social Care Scrutiny Committees in Waltham Forest were both

invited to this meeting. This was customary when there were items relating to Barts Health NHS Trust.

2. APOLOGIES FOR ABSENCE

2.1 Apologies for absence were received from Cllr Begum from Tower Hamlets and Cllr McAlmont from Newham.

2.1 Other apologies were recorded from Cllr Emmerson from Waltham Forest, Dhruv Patel from Corporation of City of London and Terry Huff (Chief Officer, Waltham Forest CCG).

3. DECLARATIONS OF INTEREST

3.1 Cllr Hayhurst stated that he was a member of the Council of Governors of the Homerton University Hospital NHS Foundation Trust.

4. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

4.1 The minutes of the meeting held on 20 November 2014 were agreed as a correct record at the matters arising on page 3 were noted.

5. TRANSFORMING SERVICES CHAINGING LIVES PROGRAMME – A CASE FOR CHANGE AND NEXT STEPS

5.1 The Committee gave consideration to a report from NHS North and East London Commissioning Support Unit on the latest stage of the Transforming Services Changing Lives Programme now known as 'Transforming Services Together'.

5.2 The Chair welcomed to the meeting Dr Sam Everington (Chair, Tower Hamlets CCG), Dr Steve Ryan (Medical Director, Barts Health NHS Trust), Mr Neil Kennett-Brown (Transformation Director – Newham, Tower Hamlets and Waltham Forest CCGs), Dr Zuhair Zarifa (Chair, Newham CCG), Ms Deborah Kelly (Deputy Chief Nurse – Patient Care and Experience, Barts Health NHS Trust), Mr Steve Millington (Consultant Orthopaedic Surgeon, Barts Health NHS Trust), Ms Jo Carter (Stakeholder Relations Manager, Barts Health NHS Trust), Mr Satbinder Sanghera (Director of Partnerships and Governance, Newham CCG), Mr Don Neame (Director of Communications NHS NE London Commissioning Support Unit) and Ms Claire Lynch (Communications Manager, Transforming Services Together, NHS NEL CSU)

5.3 Members also gave consideration to a presentation "*Transforming Services Together – Delivering a world-class healthcare service in east London*" which

was jointly presented by Drs Everington, Ryan and Zarifa as well as Mr Millington and Mr Kennett-Brown. Each introduced a section of the presentation as follows:

a) Dr Everington explained that the area is experiencing an increase in population and an increase in the prevalence of Long Term Conditions. 5% of patients are now managed in an integrated team. Many patients can now opt to die at home and there is also a great awareness of the need for the system to be more efficient. The vision they were working towards was that in 10 years time there would only be half the number of attendees at outpatients as there was now. They were utilising the latest 'Apps' to improve how they worked and to improve care pathways. The condition of NHS estates was also a serious problem. On diabetes for example they were now managing nearly all cases in a GP setting. The drive towards centralisation of specialisms was an important factor in improving patient outcomes as clinicians could have impact over a wider area and yet be available on a mobile phone. Much work was being done on joining up care pathways. Secondary care could only be responsible for 15-20% of people's health and wellbeing. The role that other stakeholders play must be emphasised as schools, for example, have a much greater opportunity to be engaged with the mental, social and physical health of children. The local health economies faced very significant challenges with savings of £28m required in Tower Hamlets and £53m in Newham in 2015/16. The advent of Social Prescribing was to be welcomed and had great potential. Typically a GP had 60 consultations per day. The system also needed to connect better with the voluntary sector. There was a need to look at different ways of segmenting the population. Taking advantage of IT need not necessarily be a problem for older people and there were examples of octogenarians happily using Skype technologies for example. The key issue was support and encouragement.

b) Dr Zarifa described the work in Newham on improving the service provided to young diabetics where only 11% of young people had been safely controlling their conditions. In the past clinics had been scheduled to suit clinicians rather than the patients. After surveying patients they adopted new ways or working including use of texting to provide quick advice to those attending their clinics and for the first time children and teenagers were appointed as patient champions and contributed to the re-commissioning plans for the diabetes service.

c) Dr Ryan stated that a key part of the change programme was on improving staff attitudes and their Older People Services Programme had make progress here. He also outlined their 'Great Expectations' maternity services programme and the 'Stepping into the Future' programme which was being rolled out at Whipps Cross. As part of the latter much progress had been made in improving the pathways for renal dialysis patients. Overall the levels of complaints were going down and they soon hoped to match the outstanding performance here of the Homerton. Cancer waiting times continued to be a challenge. They had just seen a first draft of the

latest CQC report on Whipps Cross, which would be published in March. It would be very challenging particularly in relation to staff attitudes and they were working on an action plan in response. On staff attitudes much was being done in response to the Francis report such as improving the whistleblower policies and having zero tolerance for bullying. It was important too to talk about the successes in the Trust's services and they could be proud of the collaborative work at Newham Community Health Services and the success of their stroke patient pathways. The success of the major trauma unit at Royal London was double edged though in that it had a knock on effect on waiting times for elective surgery. He reiterated that this was a "here and now" programme and incremental changes were being made rather than adopting a big bang approach. It would not be possible to make the levels of savings required through salami slicing and there was a need for major restructures to start happening now.

d) Mr Millington stated that it was important for Members to be aware of the scale of the problems nationally facing the NHS. East London was nationally one of the most challenged sectors for meeting the '18 week wait' target. In the area of Orthopaedics, East London would require 100 more orthopaedics consultants now in order to meet current government targets. At the Royal London they saw the same number of orthopaedic patients as in the other three hospitals in the Trust put together and the Trauma Centre did put pressure on the capacity for elective surgery. He stated that much progress had been made at Newham and they now had a surgical gateway centre there also to improve patient flows. They were working on pre re-habilitation programmes and on Enhanced Recovery Programmes to improve the follow up treatment. They were centralising specialist functions while ensuring that patients could get follow up outpatient services closer to home and this had greatly reduced the length of stays. Rapid improvements in medical care were also impacting on patient flows. For example an individual recovering from knee replacement surgery now could be up and walking the following day. Much progress was also being made at Newham with the specialist children's out-patients site there and they were now seeing 20K more patient episodes there. Out patients facilities could grow there because of easy access and good parking provision for the public. Dr Ryan added that allied to this, specialist children's surgery would be focused on the Royal London so that patients could get a dedicated children's surgery service.

5.4 The Committee gave consideration to a tabled joint statement from the Healthwatch organisations covering City, Hackney, Newham, Tower Hamlets and Waltham Forest. Mr Kennett-Brown responded to it on behalf of the NHS partners present stating that the Transforming Services Together programme was about focusing on the impact on the wider health system of changes to the acute system and social care. There were 9 'clinical workstreams' and 5 'enabler workstreams'. He stated that this programme wasn't about a system shock with one or two huge changes. There were a number of strands that the NHS could get on with and were doing so including making progress on the diabetes project in Newham or in maternity services in relation to

improving clinical protocols around caesareans. The Consultant Midwife working on this part of the programme was looking at issues around home birthing or on having more birthing beds in the system. Some work was needed across the whole system however and this would involve not just the 3 CCGs in the programme but the wider cohort of 7 CCG in east London.

5.5 The NHS representatives then answered detailed questions from Members and during the discussion the following points were noted:

a) Mr Kennett-Brown commented that the NHS did not need to consult on every small element of the programme but, if there were significant proposals for change, then those would be part of a consultation. Members took issue with this pointing out that a site strategy on changes as complex as this would need full consultation. They asked if the timeline chart relating to Jan-Mar 2016 (p.10 of the presentation), could be amended by replacing the words "consultation if applicable" to "consultation where applicable". Officers agreed to this.

b) Members asked if it was possible to get a breakdown and cost analysis across the 9 clinical and 5 enabler workstreams of the programme with an indication of the expected savings on each. This would allow Members to provide some challenge from an accountability and transparency point of view. Officers undertook to provide this.

ACTION	**a) The CSU/Programme Director to prepare for the next meeting a breakdown of what is hoped to be achieved and a cost analysis of potential savings for each of the 9 clinical workstreams and the 5 enabler workstreams in the *Transforming Services Together* Programme.** **b) That the timeline document for the programme be amended to read "Consultation where applicable" instead of "if applicable".**

c) Dr Everington pointed out that the asset strategy element of the programme had great potential and that one aim was that hospitals should have a GP Practice on their sites. In response to a question on finances, he replied that the current fiscal situation was making decision making more challenging, giving an example of Tower Hamlets CCG having to go all the way to a Health Minister for a decision about a site in Tower Hamlets as NHS Property Services had been unable to make a decision.

d) Members expressed a concern that there appeared to be no role for Councils in the projected governance structures. Mr Kennett-Brown replied that local authorities were represented on the *Transforming Services Together* Board. The Chairs of local Health Scrutiny committees, the Chairs of Health and Wellbeing Boards, the Directors of Public Health and Directors of adult social services from the participating boroughs in the programme were all involved in meetings. It was also noted that local authorities were also involved in

strategic estates discussions as they had a great interest in key worker housing, in particular relating to nurses housing.

e) The work on youth diabetes involved a borough by borough strategy across east London and prevention work was key. Getting young people involved in sport was an important factor in tackling childhood obesity, a major causal factor in diabetes, which was proving to be a health 'time bomb'. Another aspect was limiting the amount of fast food shops located near to school premises. Dr Everington added that getting diabetic children back to normal weight has an astonishing impact on reducing and even eliminating their condition.

f) Members asked how confident the financial modelling for the programme could be considering the levels of borrowing at Barts Health. Mr Kennett-Brown replied that they would evaluate all these factors from a financial perspective. He re-iterated that overall however the programme was clinically led.

g) In relation to older people with complex needs there was a need to improve the co-ordination of services and for the NHS to improve how it shared data. The move towards 7 day working in trusts should help address this as there was a concern about life expectancy rates being worse at the weekends. Generally, hospitals were not healthy places for frail older people to be, Dr Everington added. On the issue of data, Dr Evernington pointed out that matters were not being helped by the current care.data debacle. He was involved in a pilot project whereby 50% of patients in his group now had direct access to their medical notes online.

h) In relation to delayed transfers of care, it was noted that in Hackney the CCG had given an additional £4m to the Council for care packages. The officers pointed out that there would be movements in both directions and the Better Care Fund was all about such integration.

i) It was noted that the NHSE, Monitor and the NTDA had employed McKinsey's to carry out a review of 12 challenged health economies nationally and east London was one of these. The *Transforming Services Changing Lives* programme had actually commenced before the 'challenged health economies' report had been produced. Financial challenges in East London had been clearly identified but with the significant increase in population in the area it had become increasingly obvious that it would not be possible to close any service such as an A&E in the area because that need would have to be replaced. Dr Everington added that the traditional approach in the health service had been to create more bed spaces but this was no longer practical and there was a need instead to do things in a different way, hence the focus on aiming to reduce outpatients visits by 50% and enabling more patients for example to die at home should they choose to.

j) A concern was expressed about what would happen to City residents who might go outside the WEL CCG areas for treatment. Mr Kennett-Brown replied that City and Hackney CCG had to focus on what was provided in the

community rather than on what hospital patients might choose to attend. Overall the NHS in East London had to deliver a system that worked best for them. It was noted that UCL Partners had done work on how patient flows worked across the system and indeed the recent changes to specialist cancer and cardio services had very much been driven by research on patient flows across the whole system. Dr Ryan added that Barts Health was working on having a single IT system with Primary Care across Tower Hamlets, Newham and the City.

k) In response to a concern about the urgency of getting the savings programme back on track Dr Ryan stated that they now had the best processes in place that they ever had. Both Referral to Treatment rates and Patient Tracking Lists were showing improvements.

l) Average stays in Orthopaedics were now down to one week. Nurses were seeing high volumes of patients and once patients were physically ready the focus was to ensure their discharge was not delayed. Mr Millington added that in Orthopaedics they had to liaise with 11 different local authorities on getting discharge schemes sorted out.

m) Dr Everington pointed out that a key point with discharge was to help patients on their journey and to ensure that people felt that their local hospital was 'their hospital'. Patients instinctively had a massive loyalty to their local hospital. Having said that the stroke and cancer-cardio centralisations were really saving lives and the new cardiac centre at Barts would do the same. Mr Millington added that if patients had their outpatient appointments at their local hospital and had continuity of care this allayed their fears.

n) Members expressed concerns about the operation of the marginal tariff on emergency care and how for a Trust like Barts it was cheaper for them if they were able to outsource some patients to the private sector because of the perverse incentives in the operation of the tariff system. Dr Ryan explained that they negotiated deals with private providers so the Trust didn't lose out. The aim however was to end this practice within a year or so. There would also be a focus to get the numbers of patients waiting longer than 52 weeks down. As part of the process they obviously assessed the risk of harm to patients who might have to wait more than 18 weeks.

o) On the issue of bullying and the forthcoming CQC report Dr Ryan stated that they worked on the principle of collaboration between stakeholders so there should be no surprises when CQC reports came out. The latest CQC report on Whipps would be challenging however. It would also raise issues about waiting times. On the bullying issue the Board was taking a lead on pushing through improvements here. Dr Ryan stated that as Medical Director he himself had taken serious action against bullying cases and cases where patients were shown incivility or disrespect. In terms of employee morale it was important that staff also respected each other and understood better the pressures colleagues were under.

p) A Member pointed out that the 2013 CQC report had highlighted bullying then but no progress appeared to have been made. Dr Ryan stated that Professor Duncan Lewis had carried out an external report and the recommendations were being acted upon. He cautioned that this would take more than a year to start delivering results. He noted that the CQC itself had bullying issues within its own organisation. Large change management programmes required training of all staff and the Older Persons Services Programme had cost £1m to implement, for example, as every member of staff had to be taken off wards for a week.

q) Ms Kelly stated that staffing was a national issue and was a central focus of their work. Transport links to some of their sites meant that it was often difficult to recruit staff and there was an added housing challenge for student nurses for example. There were also challenges in recruiting to specialist areas. The changing pace of work, the increase in acuity of patients put a strain on staff. The impact of working in the trauma team long term was a concern and working on the front line of nursing now was much different than when she had first trained. A lot needed to be done to get the culture right and to make the roles attractive and to ensure there is enough support was in place for staff. She added that up to now nurses were greatly encouraged to specialise but now there was a need for nurses to be able to work across a wider range of care pathways. It was difficult to recruit cancer nurse specialists she added. There was a need to think about re-creating generic roles in nursing but to maintain the integrity of these roles. Dr Everington added that there was a need to develop nurses' roles and to bring in new skills. There was often great talent among staff who didn't possess formal qualifications for example and there was a need to rethink career pathways.

5.6 The Chair thanked the NHS representatives for their presentation and for their attendance. Mr Kennett-Brown stated that the next stage would be to come back to INEL around July to present the next phase of the Programme. The Chair stated that she looked forward to seeing how the programme would develop and that a date would set for this closer to the time.

RESOLVED:	**That the reports and discussions be noted.**

ACTION:	**Overview and Scrutiny Officer to convene a meeting of INEL in late July to take forward the next stage of the consultation on *Transforming Services Together* programme.**

NHS England

PRIMARY MEDICAL SERVICES FROM PORTSOKEN SITE 1st April 2015

Introduction

In April 2010 a service level agreement was signed by City Wellbeing practice to deliver Primary Medical Services from the Portsoken site on two sessions per week. Registration from this site covers residents from the east of City of London (Portsoken) ward. The population of the surrounding areas were covered primarily by practices within the South West Locality of Tower Hamlets which result in the lack of primary care provision for the Portsoken ward. The opening of the Portsoken site provided access to primary care for these residents.

The aim of this service is to provide primary medical services for the residents; it is not intended as a walk in centre.

With the absence of primary and secondary care services, the Portsoken had co-location with other services from Bart's Health namely; foot services, women's Health and diabetes specialist nurse sessions from the onset of this contract.

The Primary Medical Service provider was also responsible for the operational management of the site via the receptionists and practice manager during the sessions that the practice is operating. This includes receiving deliveries, contributing to the development of the operational policy for the premises, managing communications and liaising with the facilities management services.

Within the Tower Hamlets CCG Estates strategy both City Wellbeing, the previous provider of services at Portsoken and the new provider, Whitechapel Health Centre, will in 3-5 years relocate to the new health centre at Goodman's Field. Upon completion, Portsoken will cease to exist as a separate entity; the new health centre will absorb all the patients within the east of City of London.

Contract Management

In December 2014 City Wellbeing gave notice to NHS England (London Region) of its intention to relinquish the contract for the Portsoken site. NHS England (London Region) did not initially accept this notice; it gave the practice an opportunity to discuss the service contract and consider options for continuing. However, the practice opted to proceed and confirmation was received by NHS England (London Region) from the practice at the end of December 2014 of their stated position to withdraw from the contract. It was agreed that the end date would be 31 March 2015.

Re-provision of services

NHS England was concerned to ensure that there was no loss of or reduced access to primary care for people living in the Portsoken ward. Due to the requirements of the Tower Hamlets CCG Estates strategy the Portsoken service could not be re-procured through a single tender waiver. NHS England (London Region) therefore made an approach to Whitechapel Health Centre to seek their agreement to provide primary medical services from the Portsoken site. Whitechapel Health Centre accepted the offer and agreed to commence

provision of service at Portsoken from 1st April 2015. Whitechapel Health Centre is run by AT Medics and is located at a similar distance from Portsoken (0.6miles) as the Whitechapel practice (0.7 miles).
In early March a letter was sent to all City patients registered at Whitechapel to advise them of the new GP provider arrangements taking effect from 1st April.

Patients were informed that their registration would automatically transfer to the new practice on 1st April 2015 and that they would continue to be able to use Portsoken. For patients wishing to go back to being registered with City Wellbeing Practice or wishing to register with a different practice, information was provided in the letter explaining what they needed to do.

NHS England (London Region) has agreed an improved service specification for the Portsoken centre with the new incoming provider. This includes an initial deep clean of the premises and implementation of an ongoing cleaning schedule to meet NHS England (London Region's) infection control toolkit best practice.

Patients at the centre will have access to the full range of essential and enhanced primary medical services provided by Whitechapel Health and can access appointments from both their main practice location and the Portsoken Centre. The service will include care for people with long term conditions, diagnosis, prevention, immunisations and screening. Patients will need to register with the providing practice in order to receive care at the Portsoken Centre.

Patients will have access to Out of Hours services and home visits, as clinically necessary. Out of hours service provision will be arranged in the same way as for all other patients registered with the practice.

Attracta Asika
NHS England (London Region)

Committee:	Date:
Health and Social Care Scrutiny Sub Committee	5 May 2015
Subject: Healthwatch City of London Update	**Public**
Report of: Healthwatch City of London	**For Information**

Summary

The following is Healthwatch City of London's update report to the Health and Social Care Scrutiny Sub Committee.

This report covers the following points:

- Barts NHS Trust
- Workshop on Integrated Care
- Healthwatch attendance at PLACE assessments

Recommendation(s)

Members are asked to:

- Note this report, which is for information only

Main Report

Background

Current Position

- **Barts NHS Trust**

Healthwatch City of London has been in contact with Barts Trust over the lack of stimulation in wards that care for older people. Following feedback from patients and input from nursing staff at Barts our ongoing concern has been lack of engaging activities which could improve the quality of the patient experience and well being. Televisions have been purchased for Thistle ward at Newham University Hospital but are yet to be installed and at Royal London the televisions can only be used by purchasing a TV card which many patients cannot afford. Healthwatch met with the Chair of Bart's Health Trust Sir Stephen O'Brien and the Deputy Chief Nurse for Barts and raised these issues highlighting the fact that the television issue had been ongoing since July 2014 which is not acceptable. Since the meeting we have now heard from Sir Stephen O'Brien that the scope of the work at Newham has now been finalised and that the PFI partner will work closely with the ward staff in order to ensure that the installation will be

undertaken as quickly and as efficiently as possible. We also requested the older person's wards be given priority for a new scheme of volunteering that will enable items such as board games and puzzles to be used to greater effect. A volunteer has been organised for the older persons ward at Royal London.

Whipps Cross University Hospital

The Care Quality commission – CQC – inspected the Whipps Cross Hospital in November 2014 and following the inspection report on the quality of services at the hospital the Trust Development Authority (TDA) announced that Barts Health Trust – which is the Trust responsible for Whipps Cross Hospital - should be placed into 'special measures'. The CQC report can be viewed here: http://www.cqc.org.uk/location/R1HKH

The local Healthwatches including the City of London Healthwatch have been heavily involved with the CQC and the subsequent Quality Summit which led to the TDA decision. It is sincerely hoped that this decision will lead to the necessary changes being implemented to ensure local patients are getting the best possible care from the hospital. It is acknowledged that very few patients are City residents but City of London Healthwatch wants to ensure that every City resident is provided with excellent hospital care.

All the local Healthwatches are pleased that the patient concerns raised over the last couple of years have subsequently been identified by the CQC and are now being taken seriously by the TDA with a clear recognition that changes are needed. Patient care and safety must remain the paramount focus during this time of change. We would also like to ensure that staff are supported during this difficult time and they are recognised and valued for their hard work and areas of excellent care.

Healthwatch City of London would welcome wider patient and public community involvement in the improvement plans and patient and public feedback on the quality of care received in other parts of Bart's Trust.

Meeting with the Trust Development Authority

A Healthwatch City representative met with the TDA along with other local Healthwatch to discuss the situation at Barts Trust. CQC reports are expected in May on Newham and the Royal London. The meeting focussed largely on Whipps Cross.

'Special Measures' was differentiated clearly by the TDA from the appointment of a special administrator. Additional resources and support have already been sent into Whipps Cross which means strengthening the management team and not providing extra money.

The focus of the TDA was almost entirely on correcting faults that have been revealed and any long term and more strategic issues will be left for the future. The TDA were constructive in their willingness to involve Healthwatch representatives on a detailed a regular basis in the activity underway.

- **Workshop on integrated care**

Issues relating to delayed care and an inconsistent patient pathway particularly for City patients with GP's in Tower Hamlets has been raised by Healthwatch with the City and Hackney CCG. A workshop was recently organised on 17 March 2015 at the Guildhall by the CCG to look at integrated care - specific attendees were invited from across the boroughs to look at proposals for integrated care. A representative from Healthwatch City attended to provide the patient voice. The most important aspect to the workshop was that attendees from City, Hackney, Tower Hamlets and Islington participated to accommodate the fact that people from Islington were Neaman practice patients and City residents were registered with GP's outside the City boundaries. Some other issues highlighted included:

- There is some confusion over nursing services - City and Hackney residents receive nursing care from the Homerton but some residents with Tower Hamlets GPs receive nursing care from Tower Hamlets
- The importance of sharing care records and IT systems across boundaries
- A single point of access to pathways is needed for city residents including those with GP's beyond the City boundaries
- The different boroughs have different names for staff e.g. care navigators/care co-ordinators which can cause confusion
- There are Community pharmacists in each quadrant of City and Hackney which was agreed by the GP's attending to be a very useful resource

One of the case studies related to the workshop was the following piece directly from a service user of mental health services in City and Hackney:

Mental Health Services – a patient's view

I have been following the consultation on the changes to Older Adult Functional Inpatient Services in City & Hackney and Tower Hamlets by the East London Foundation Trust which involves the facilities moving to Mile End.

As a City resident who has experienced mental health issues I already know what it is like to have to travel to Hackney to use the Homerton facilities as an inpatient for mental health services. You are taken away from the area you know and the surroundings can often seem alien to both residents and their families. I am concerned that the buildings for older people are moving to Mile End - this will be an even longer journey for the families of City residents. At a

time when you are at your most vulnerable both patients and their visitors need surroundings that are familiar and comfortable to them.

Dementia can be a hugely distressing state and whilst attitudes and understanding amongst staff at hospitals has greatly improved we still need to ensure that people are treated with the dignity required for living with dementia. Many changes take place as we get older - changes in relationships, our physical health and lifestyle changes. To have to go to a different borough for our treatment is another change that could have a detrimental affect on treatment.

A small ward at Barts would be ideal for City residents although I know this is a big ask! It is difficult for people to visit their loved ones in the Homerton and will be even worse in Mile End – there are limited travel links to the City and if family are working this can mean them travelling in rush hour. My consultant used to be based at Barts but he has now moved to the Donald Winicott Centre in Hackney which is a long journey for me. Why do City residents always get pushed to other boroughs? I have recently attended the consultation events run by East London Foundation Trust and the Kings Fund on these issues where I gave my views from the perspective of a City resident – although we are small in numbers we need to continue to ensure our voice is heard.

- **Healthwatch attendance at PLACE assessments**

  The Healthwatch representative has attended PLACE assessments with Barts Health NHS Trust at Newham University Hospital, Mile End Hospital and the Royal London and will feed back verbally at the meeting. Many city residents receive their care to the west in the hospitals of UCLH Foundation Trust. We have participated in PLACE inspections at the National Hospital for Neurology and Neurosurgery and will be doing so at University College Hospital and RNTHE hospital.

Conclusion

The Healthwatch City of London representative will provide an update on the areas raised in this report at the next meeting.

Healthwatch City of London

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Committee:	Date:
Health and Social Care Scrutiny Sub Committee	05 May 2015
Subject: Review of Health Overview and Scrutiny Functions	**Public**
Report of: Director of Community and Children's Services	**For Decision**

Summary

At its meeting on 25 November 2014, the Health and Social Care Scrutiny Sub Committee received a report highlighting how recent national developments have impacted on the way local authorities exercise their health overview and scrutiny function.

Members agreed that although there are no concerns that the City's arrangements are flawed, the Health and Social Care Scrutiny Sub Committee should take the opportunity to examine if there are any areas where its health and social care scrutiny functions could be enhanced.

Members agreed the proposal for a two phased review, comprising firstly an initial stocktake of its current position, supported by officer's research of best practice elsewhere and then to recommend to a future meeting and, if necessary, to the Grand Committee what changes are needed to the health overview functions in the City as a result.

This report presents the conclusions and recommendations drawn from the two phased review.

Recommendation(s)

Members are asked to:

- Note this report and the report of the review of the health overview and scrutiny functions in the City, prepared by Shared Intelligence 2015 (Appendix 1)
- Endorse, in principle, the conclusions and recommendations from the working group of Health and Social Care Scrutiny Sub Committee (Appendix 2)
- Note and review indicative proposed work programme for the City of London Health and Social Care Scrutiny Sub Committee 2015 – 16 (Appendix 3)
- Request Officers to evaluate the resource implications and the implications related to the Terms of Reference of implementing the changes and report back to the next meeting of the Sub Committee.

Main Report

Background

1. At its meeting on 25 November 2014, the Health and Social Care Scrutiny Sub Committee received a report highlighting how recent national developments have impacted on the way local authorities exercise their health overview and scrutiny function.

2. Members agreed that although there are no concerns that the City's arrangements are flawed, the Health and Social Care Scrutiny Sub Committee should take the opportunity to examine if there are any areas where its health and social care scrutiny functions could be enhanced. This would also be in line with earlier recommendations that the City's health and social care scrutiny function ought to be the subject of a review no later than April 2014.

3. Members agreed the proposal for a two phased review, comprising firstly an initial stocktake of its current position, supported by officer's research of best practice elsewhere and then to recommend to a future meeting and, if necessary, to the Grand Committee what changes are needed to the health overview functions in the City as a result.

4. Phase I of the review was undertaken at the Health and Social Care Scrutiny Sub Committee meeting on 2 February 2015. Members were presented with an initial stocktake report of the current position of health scrutiny in the Corporation and a comparison with approaches in other local authorities; this was followed by a discussion facilitated by Shared Intelligence at which six Members of the Health and Social Care Scrutiny Sub Committee were present along with relevant officers. A note of the discussion as prepared by Shared Intelligence is presented in Appendix 1.

Current Position

5. Following the Phase I review and Sub Committee meeting in February, a working group was established, comprising two Members and two officers to draft conclusions and recommendations for incorporation into a report. These conclusions and recommendations are presented in Appendix 2.

Proposals

6. From its analysis, the working group has drawn the conclusions presented in Appendix 2, on which it has based a number of recommendations to the Health and Social Care Scrutiny Sub Committee.

7. At this stage the cost of implementing the recommendations has not been evaluated, if Members agree, in principle, to all or some of the recommendations of the working group Officers will then carry out an evaluation and report back to the Sub Committee

Corporate & Strategic Implications

8. The proposals outlined within this report fit with the Community and Children's Services Departmental Business Plan priority to safeguard children and adults from abuse and neglect wherever possible and deal with it appropriately and effectively where it does occur.

9. The working group is confident that the recommended improvements will make health scrutiny more robust and effective when monitoring the actions of Health providers that serve City residents.

10. By gathering and scrutinising information from a variety of sources the Health and Social Care Scrutiny Sub Committee will be in a strong position to act and advise if action is deemed necessary.

11. Many of these improvements could also be applicable to other Committees. For example, other committees could benefit by considering whether they should obtain corresponding information on complaints to obtain a better understanding of the service user's perspective.

Conclusion

12. This report presents an analysis, conclusions and recommendations of the phase I review of the City's Health and Social Care Scrutiny Sub Committee.

13. Members are asked to:

- Note this report and the report of the review of the health overview and scrutiny functions in the City, prepared by Shared Intelligence 2015 (Appendix 1)
- Endorse, in principle, the conclusions and recommendations from the working group of Health and Social Care Scrutiny Sub Committee (Appendix 2)
- Request Officers to evaluate the resource implications for the Sub Committee of implementing the changes and any implications related to the Current Terms of reference and report back to the next meeting of the Sub Committee.

Appendices

- Appendix 1 – A report of the review of health overview and scrutiny functions in the City, Shared Intelligence 2015.
- Appendix 2 – Conclusions and recommendations from the working group of Health and Social Care Scrutiny Health and Social Care Scrutiny Sub Committee.

Background Papers:

Review of Health Overview and Scrutiny Functions, Report to Health and Social Care Scrutiny Sub (Community and Children's Services) Committee, 02 February 2015

Review of Health Overview and Scrutiny Functions, Report to Health and Social Care Scrutiny Sub (Community and Children's Services) Committee, 25 November 2014

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APPENDIX 1:

Report of the Review of Health Overview and Scrutiny functions

Prepared by Shared Intelligence (2015)

Last November the Health and Social Care Scrutiny Sub Committee of the Corporation of London decided to conduct a review of its Health Scrutiny functions.

The Sub Committee (like others around the country) was prompted to review its functions by several inter-related factors. First were the Jay and Francis reports (into systemic failings of governance and oversight in social care). Second were the new responsibilities which have transferred to local authorities for health commissioning (in terms of budget, management, and governance). Finally there is the new framework for Health Scrutiny (and associated Department for Health guidance) which extends to powers of Health Scrutiny to a larger number of health providers commissioned by local authorities themselves.

The approach agreed for the review of Health Scrutiny had two stages. First was an initial stocktake report of the current position of Health Scrutiny in the Corporation and a comparison with approaches in other local authorities; this was discussed at the 2 February meeting of Health Scrutiny at which 6 Members of Health Scrutiny were present along with relevant officers.

Six questions had been devised in advance by officers to help give structure to the discussion and subsequent review, which Shared Intelligence had been asked to facilitate:

1. What should the scope and objectives of Health Overview and Scrutiny in the City be and what is the role of Members to that?
2. How can Members be supported to be more effective in that role (training, guidance etc.?)
3. Who and what should be routinely scrutinised?
4. How can we gain a better understanding of user experiences?
5. What information do we need?
6. Do we need to agree a revised Terms of Reference to reflect a refreshed statement of the aim and objectives of Health Overview and Scrutiny and the role of Members?

This note of the discussion is intended to inform the second stage of the review by recording the views of Members and in effect, setting a brief for the brief reflecting the views of Members. In the second stage two Members will work with an officer to look at these questions in more detail and being their conclusions and recommendation back to the Sub Committee in May 2015.

Response of Members to the six review questions

On some of the six questions Members gave a more detailed steer than others, and this may indicate the areas of the review Members view as most important. Taking the six questions in turn the views of Members were as follows:

1. *What should the scope and objectives of Health Overview and Scrutiny in the City be and what is the role of Members to that?*

Members agreed with the stocktake analysis presented by officers who described the role of Health Scrutiny as holding the City of London's health and social care providers to account, and ensuring the voices of the public and service users are heard. In terms of the detail beyond this, Members felt the main purpose of phase 2 of the review was to look at that detail.

2. *How can Members be supported to be more effective in that role (training, guidance etc.?)*

As with the previous question, this probably needs to be addressed after the review reaches more concrete conclusions on the questions which follow.

3. *Who and what should be routinely scrutinised?*

The stocktake report had raised the issue of balance between scrutiny of external bodies, versus services commissioned by the Corporation itself. There was a consistent view from Members that the issues and organisations they looked at tended to be arrived at reactively, and were also at times *'lop-sided'* towards health, compared to social care. The issue of health focus over social care was further complicated by the fact that looking at 'health' tended to mean looking at organisations external to the Corporation, while 'social care' would include the Corporation itself and organisations it has commissioned.

It was clear Members were keen for more balance in future, ad a more planned and proactive approach.

One thing Members were keen to see was a full list of all the health and social care providers Health Scrutiny has powers to question (the legislation[1] refers to each such provider as a "responsible person"). It was suggested this list might address several issues at once; Health Scrutiny could take a wider view and avoid investigating only familiar issues or providers, Committee Members could take a more planned and proactive approach to their future work programme, a better balance might be achieved between looking at external organisations and at those commissioned by the Corporation, and it would be easier for the public and users to know whether Health Scrutiny is a route for them to raise a question or concern.

4. *How can we gain a better understanding of user experiences?*

User experience (and failures to seek or consider it) was a key issue in both the Jay and Francis reports; meaning both the extent in which information about users' views and experiences are proactively sought and considered, and the extent the public are made aware of bodies such as Health Scrutiny to whom they can bring their concerns.

The recent co-option to Health Scrutiny of Healthwatch City of London provides a starting point for increasing the role of user experience in Health Scrutiny. However, the Jay and Francis reports, and subsequent Department of Health guidance on Health Scrutiny emphasise the need to strengthen the voice of local people, and to keep open effective channels by which the public can communicate concerns. This implies that one co-opted member of Health Scrutiny is a good foundation, but probably needs to be part of a strategic approach to incorporating user experience.

[1] The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Members suggested another source of insight into user experience might be comments and complaints received via the GP practices, or from adult social care clients; one Member reported that the board of Barts Health Trust review a sample of comments and complaints as part of every board meeting.

In terms of taking a more strategic approach overall, Members felt a crucial way they can add value is by '*triangulation'* – meaning Health Scrutiny should compare the picture portrayed by management data and information, with the picture coming from user experience, and then ask two questions. The first is whether the user (or qualitative) picture supports the management (or quantitative) picture. The second question is how the combined picture compares to the level of service expected; i.e. to triangulate the standard of care expected, with both the management view and user or patient view.

In terms of ensuring the public are aware of the role of Health Scrutiny and how it can help them influence services or address concerns, an important issue for Members was communication; how is the role (or indeed existence) of Health Scrutiny described, and where is it publicised? This might be a simple issue of communication, but might also be an issue of how the Term of Reference are worded, as well as how meetings themselves are billed and publicised.

A final point slightly separate from user experience, was to consider the role of Health Scrutiny in terms of whistleblowing – i.e. where individual professionals within the system have serious concerns they feel are not being addressed through the normal management channels. The need for Health Scrutiny to be a route for whistleblowers to voice their concerns and have them looked into, is a key theme of both the Jay and Francis report, but the issue for the review is how that should happen in practice.

5. What information do we need?

One of the key findings of the Jay and Francis reports was the need to obtain the right kinds of information; without the right information then oversight cannot be effective. But what is the right kind of information, and what is it practical to request in an area of public services which is often seen as being deluged by information and performance systems?

The need to have the right kinds of regular information and data prompted the greatest amount of discussion and interest among Members. There was a strong desire for Health Scrutiny to adopt a more systematic approach to reviewing management information and data; to be clear on what Health Scrutiny is trying to achieve by looking at such information, and what information is therefore needed, *'the key question is - what information do we need?'.*

The form that might take was an important issue for the review to address. It might be a set of *'standardised KPIs'* which might include indicators which health providers already use – or new indicators created by Health Scrutiny. It might mean identifying some *'fundamental standards'*. It might include having thresholds or '*Red/Amber/Green'* markers, but this might raise new challenges, not least how to avoid arbitrary thresholds? For example there have been instances where public bodies have been assessed as "4-star", or "Excellent" one week, only for serious problems to emerge the next. In such cases those in charge are often asked *'who decided that x was a robust indicator of good performance?'*.

The issue of information and data also raised concerns that for complex activities (such as health and social care) the temptation may be to measure things which are easy to measure, rather than getting to the heart of issues of quality and performance.

Finally of course, was the need for Health Scrutiny to add value, and not duplicate other processes or the work of other bodies (e.g. the CQC, or local commissioners). Some Committee Members were particularly keen to consider the role of Health Scrutiny in relation the Health and Well-being Board (HWB); although the HWB's role is to set strategic direction and does not include scrutiny there might be a perception among health providers that both bodies are asking the same kinds of questions (Shared Intelligence had seen from their own research that this was becoming an issue nationally). The same point was made in relation to the Inner North East London Joint Overview and Scrutiny Committee.

6. ***Do we need to agree a revised Terms of Reference to reflect a refreshed statement of the aim and objectives of Health Overview and Scrutiny and the role of Members?***

This question, like the first question on overall scope of the Sub Committee, seemed to be something which needed to be addressed at the end of the review process. In any case, a change to the Terms of Reference of the Sub Committee could only be agreed by the Community and Children's Services Committee to which the Sub Committee reports.

Other issues: potential conflict of interests

If Health Scrutiny is to begin looking more at service provision which is commissioned (or delivered) by the Corporation itself, then the role played by the Director of Community and Children's Services in supporting Health Scrutiny will need to be considered, as he is of course also responsible for commissioning health and social care provision.

Similarly the review should also consider whether greater separation is needed between membership of the Sub Committee and its parent the Community and Children's Services Committee. The Department of Health guidance on Health Scrutiny provides describes possible approaches to potential conflicts of interest both in relation to the role of individual Members, and the relationship between Health Scrutiny and any parent Committees[2].

Suggested sequence of the review – starting with the overall goal and purpose

In our view this initial discussion has provided a useful steer and sense of direction on some specifics and some matters of principle which will inform the second stage of the review. But much more detail now needs to be considered by the small working group taking this forward.

On reflection we also suggest that there is a preferred sequence in which the issues should be considered – starting with re-stating the overall goal of Health Scrutiny (which is not something covered in the initial discussion). From this would then follow the other issues including what questions Health Scrutiny should be asking and of whom.

So our final observation is to suggest a sequence for stage two as follows:

[2] Local Authority Health Scrutiny, Guidance to support Local Authorities, Department of Health 2014 (Paras 3.1.1 to 3.1.30)

Suggest what goals Health Scrutiny should be aiming to achieve and decide how to express that succinctly? I.e. role and scope.

Who should be called to meetings and what approach should we have to select invitees?

Review the types of questions Health Scrutiny should be asking in order to achieve agreed goals and what evidence / data / information sources do we need to consider?

Scope what kinds of information can practicably be requested, collected and analysed (whilst still adding value)?

Go back and cross-check that user experience and voice features throughout. Do the same for balance between health, versus social care.

Consider the practical issues including Membership, relationship with officers, Terms of Reference, communications with partners and the public.

Shared Intelligence

February 2015

APPENDIX 2:

CONCLUSIONS AND RECOMMENDATIONS FROM THE WORKING GROUP OF THE HEALTH AND SOCIAL CARE OVERVIEW SUB COMMITTEE

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1. What should the role and scope of health and social care scrutiny be?

At the Health and Social Care Scrutiny Sub Committee meeting held in November, the Committee agreed with the stocktake analysis presented by officers.

Several issues dealt with as part of the meeting give a steer around the overall scope of Health and Social Care Scrutiny. These include for instance, achieving a better balance between health and social care services, having a more structured focus on performance data, and increasing the focus on user experience. None of these issues indicate any fundamental concerns from Members about the scope and objectives of Health and Social Care Scrutiny, but they may mean that the scope and objectives could be expressed more clearly to partners and the public.

Robert Francis QC identified the need for more clarity over which functions / objectives Health and Social Care Scrutiny intend to follow when scrutinising health and social care services. The starting point for this must be the Health and Social Care Act 2012 and related legislation which give powers to upper authorities to:

- Review and scrutinise any matter related to the planning, provision and operation of health services in their area
- To make reports and recommendations to local NHS bodies, NHS commissioned providers, Providers commissioned by the City.
- To make reports and recommendations to local NHS bodies, NHS and local authority commissioned providers and the Secretary of State.
- The Act also requires NHS bodies to consult with the local O+S committee on matters of substantial development or variation to services.
- The CfPS has recommended that that local authority scrutiny is an opportunity to act as the eyes and ears of the community
- It is also important to ensure that there is no duplication with or conflict with the Health and Wellbeing Board roles and responsibilities

Recommendation 1:

The working group recommends to the Sub Committee that it adopts the following aim:

"Through constructive challenge and scrutiny, to work with the Health and Wellbeing Board and service providers to help ensure quality services are provided to City residents and City workers, reducing health inequalities and helping everyone to stay

fit and lead healthy lives".

Within this overall aim, the objectives for Health and Social Care Scrutiny could be:

1. To exercise democratic accountability and scrutiny, representing the interests of City residents in regard to health services. This entails constructively and transparently holding service providers to account in meetings open to the public and making recommendations for improvements.
2. To achieve and maintain knowledge of patient experience in order to achieve the objectives set out in recommendation 1 above.
3. To monitor the performance of major service providers of health and social care services to City residents, with reference to the findings of NHS regulatory bodies, challenging underperformance and encouraging improvement.
4. To review and respond to any substantive proposals or consultations for service change.
5. Recognising the scope of health and social care services and the limited time available for Scrutiny means that only those matters deemed to be of greatest importance are scrutinised.

To achieve this and to make the best use of the resources available, Officers and Members will develop an annual work plan which focuses attention on those matters which the Health and Social Care Scrutiny Sub Committee judge:

- Affect a large number of residents
- Are significant service failures or matters of public concern

In delivering these objectives, the role of Members is not to be medical experts. Instead, and in line with Robert Francis QC reported view, Members are expected to make themselves aware of and pursue the concerns of City residents and workers.

2. Who should be called to meetings and what approach should we have to select invitees?

Members want Health and Social Care Scrutiny to look at a broader cross-section of all the service providers they have powers to scrutinise, and to achieve a balance between health, and social care, and between services they have looked at previously and those they have not. One important step to achieving this could be to provide Members regularly with a full list of organisations in their purview, and another might be to review the future work programme for Health and Social Care Scrutiny looking specifically at overall balance over the year.

The stocktake report had raised the issue of balance between scrutiny of external bodies, and scrutiny of services commissioned by the Corporation itself. There was a view from Members that the issues and organisations they looked at tended to be arrived at reactively, and were also at times *'lop-sided'* towards health, compared to social care. The issue of health focus over social care was further complicated by the fact that looking at 'health'

tended to mean looking at organisations external to the Corporation, while 'social care' would include the Corporation itself and organisations it has commissioned.

One thing Members were keen for the review to produce was a full list of all the health and social care providers Health and Social Care Scrutiny has powers to question (the legislation[3] refers to each such provider as a "responsible person"). It was suggested this list might address several issues at once. It would become easier for Health and Social Care Scrutiny to ensure a wider coverage and avoid scrutinising only familiar issues or providers, Members could take a more planned and proactive approach to setting their future work programme, a better balance might be achieved between scrutiny of external organisations versus those commissioned by the Corporation. Assuming this list was easily available then it might also make it easier for the public and users to know whether Health and Social Care Scrutiny is a route for them to raise a question or concern about a particular service.

Regrettably, the large number of organisations involved in providing health services means that due to the resources available the Health and Social Care Scrutiny Sub Committee is not able to scrutinise all of these.

So, the recommended solution is for individual Members to take a lead for different service areas and key organisations.

RECOMMENDATION 2:

That Health and Social Care Scrutiny Sub Committee Members take individual responsibilities for scrutinising different partner organisations

1 Member for each of the four NHS Health trusts (4 members in total)
1 Member for the Clinical Commissioning Groups
1 x Healthwatch representative for public health and social care services

The following table summarises how this approach could work:

ORGANISATION	MEMBER ROLE	SUB COMMITTEE ROLE
Health and Wellbeing Board (HWB)		HWB representative attends Sub Committee meetings at least once a year to present key developments The Sub Committee to review each year the annual Refresh of the JSNA and Health Wellbeing Strategy.

[3] The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Clinical Commissioning Groups (CCG's): • Tower Hamlets • City and Hackney	One Member to take a lead in monitoring the activities of – both CCG's.	The Chair and Accountable Officer of the CCG to present to the Health and Social Care Scrutiny Sub Committee once every two years.
GP Practices (The Neaman Practice Spitalfields, White Chapel)		Officers to review GP Patient Survey results and to alert the Sub Committee on issues related to under performance.
Hospitals / Trusts which serve City residents and workers: Barts NHS Trust (includes: The Barts Hospital, Royal London Hospital, Whipps Cross Hospital) East London Foundation Trust The London Ambulance Service The Homerton University Hospital Trust	One Member to review NHS choices information (this includes staff/ patient surveys and summary reports of patient complaints and CQC/ MONITOR reports Officers to review Annual Accounts with a view to identifying significant or key issues and cross referencing these with CCG monitoring	

	information.	The Health and Social Care Scrutiny Sub Committee to formally meet each Trust at least once every two Years.
social care services	Local Healthwatch representative on Scrutiny Committee to maintain watching brief on any news items and bring anything of concern to the O+S Chair for them to conduct further enquiries / draw matters to the Sub Committees attention as necessary. Local Healthwatch representative to review and report on contracted and in house social care provision	The Assistant Director (People) to present to the Health and Social Care Sub Committee once every two years.
Public Health (Including Dentists and , Pharmacists,)	Local Healthwatch to take a lead in monitoring activities / complaints to Public Health drawing matters to the Committees as and when necessary. Local Healthwatch representative to review and report on contracted and in public health provision	The Sub Committee to scrutinise the annual public health budget and review performance at a meeting with the Director of Public Health for Hackney and the City at least once every two years.

3. What questions should the Sub Committee be asking / how can we improve Members effectiveness?

Research of approach of other local authorities indicates best value is to be obtained from Committee meetings through Members being well prepared, participating effectively, and asking good quality questions.

Members need to ensure they are fully briefed and prepared and be confident to ask challenging questions.

Furthermore, the complexity and continual evolution of the NHS means that Members carrying out Health and Social Care Scrutiny need regular training if they are to be effective.

Member involvement in Health and Social Care, alongside the quality, depth and effectiveness of scrutiny could be better served by individual Members concentrating on a defined area and working with Officers to lead the Sub Committee's work in that area as proposed above.

By specialising in one area and building relationships with the respective organisations, each Member would develop knowledge of that area, thereby enhancing the Scrutiny approach and lead to a wider distribution of questioning amongst Members.

This could be further strengthened and supported by developing an agreed programme of training and development for Members.

RECOMMENDATION 3:

Health and Social Care training should be delivered primarily by officers in health and social care and comprise:

1. **Induction training and induction pack for all Members new to health and social care Scrutiny.**
2. **Training on the Health structure, functions and local delivery organisations and on the powers and role of Health and Social Care Scrutiny.**
3. **Annual refresher training on major developments to coincide with the annual update of the JSNA.**
4. **Targeted training in whichever topic is selected for a focussed review.**

This training could be identified as part of an annual training and development plan, in parallel with the annual work plan for the Sub Committee.

RECOMMENDATION 4:

That each Sub Committee meeting should include a regular agenda item on “action tracking” (systematically following matters up, including previous recommendations subject to resources being made available).

This could be supported by officers maintaining an electronic “action tracking” document.

4. Prioritising issues for attention

There are many aspects to health services in view of the Sub Committee’s limited resources there is a clear need to keep the flow of information to Members of manageable size to concentrate on exception reporting, flagging of issues of possible concern, and to prioritise quite ruthlessly on where scrutiny should focus its efforts.

By adopting Recommendation 2, above, a series of regular updates to the Health and Social Care Sub Committee will form part of the annual workplan.

The Sub Committee could then prioritise three or four additional subject or topic based headings to be scrutinised over a two year period and once finished move on to another set of priorities. However, each meeting will still need to leave space for urgent or reactive matters that could be agreed as items with the Chairman in between Health and Social Care Sub Committee meetings.

RECOMMENDATION 5:

The Health and Social Care Scrutiny Sub Committee will agree annually three to four topics deemed appropriate and necessary, for the Sub Committee to focus on and incorporate into its annual work programme.

Any Urgent and reactive items will be agreed by the Chairman between meetings.

5. Getting the right information

The information Members see as most vital is regular performance data presented against a set of *‘fundamental standards’*. The review should decide whether a system to show performance thresholds e.g. a *‘Red/Amber/Green’* system, would be useful to Health Scrutiny. However, the critical question the Members felt the review should consider first is “*what information do we need?’* i.e. for this question the review should start by looking at the many streams of information available and choose a manageable selection which Members can make use of, and which adds value.

The CfPS has recommended that local authority scrutiny should consider establishing a range of “triggers for action” using data and information to monitor trends. The Sub Committee needs to receive regular, timely and relevant information about the quality of health services provided to City residents. This information should come from a range of relevant sources, in order to arrive at a balanced and well informed viewpoint. Members should not be buried in mountains of information however. Instead, there should be a selective approach which could be achieved by Members specialising in one field of activity. Each Member, advised by an Officer, should decide what matters should be brought to the attention of the Sub Committee and they should each lead the Sub Committee’s questioning from their designated area.

RECOMMENDATION 6:

At its meetings, the Sub Committee or the individual Member with responsibility for specific organisations should routinely receive:

- **Summary information from the NHS choices website on standardised mortality rates, Friends and Family rating etc.**
- **Regular feedback from Local Healthwatch about any concerns.**
- **Regular feedback from Clinical Commissioning Groups about any major concerns they have with the quality of services provided.**
- **In patient survey results.**
- **GP survey results.**
- **Any reports issued by the CQC and monitor about the hospital trusts used by City residents.**

6. Ensuring that user experiences and voices feature throughout the process

There is a plethora of information about complaints and so the Sub Committee should be discerning about what information might be useful.

The quarterly Patient Safety Report, published by each Trust for their Board meetings in public, provides good summary information to gain a good general impression complaints traffic and does not endanger patient confidentiality. The appropriate Member could request any supplementary information that may be required and may then bring an issue to the attention of the Sub Committee. For example, there may be an upsurge in one type of complaint, so more information may be required beyond the Patient Safety Report.

The Sub Committee should also seek a regular flow of information from Local Healthwatch and the quarterly and annual report from the Complaints Advisory Service.

In terms of ensuring the public are aware of the role of Health Scrutiny and how it can help them influence services or address concerns, an important issue for Members was communication; how is the role (or indeed existence) of Health Scrutiny described, and where is it publicised?

RECOMMENDATION 7:

That each of the NHS Health Trusts as set out in Recommendation 2, display on their website and notice boards information summarising:

- ***the role of Scrutiny and Local Healthwatch.***
- ***welcoming views (but not individual complaints) from patients to the Sub Committee.***
- ***information on the complaints process and referral routes.***

Appendix 3:
Indicative proposed work programme for the City of London Health and Social Care Scrutiny Sub Committee 2015 – 16

An indicative work programme for the City of London Health and Social Care Scrutiny Sub Committee in 2014/15 is shown below. The programme is aimed at maintaining a strategic and co-ordinated work programme based on major areas of the City's and partner organisations' activity. The review topics take account of what is likely to be timely, relevant, and to add value. The programme incorporates the routine, on-going work of the Sub Committee and the completion of reviews currently underway.

The work programme will necessarily be subject to continual refinement and updating. Any 'future possible reviews' are those which are unlikely to be resourced until 2015/16 or later.

1.	**Implementing the new Approach to Health Scrutiny** To deliver the new approach to health scrutiny as recommended by the Working Group on the Francis report. The numerous changes include a specialist member approach and strategically monitoring the performance of the NHS trusts and Clinical Commissioning Group serving the City, with enhanced reference to key information flows. This might in due course lead to a focussed review in 2015/16 or later years; possible topics might include: • Mental health services; • The Joint Strategic Needs Assessment; • The treatment of Alzheimer's disease, and other forms of dementia; • An aspect of Primary Care services.
2.	**2015/16 Budget Scrutiny** To review the City's budget proposals for public health in 2015/16, and plans for future years.
3.	**Public Health** To carry out a review on the Council's wider actions on the transferred public health (PH) responsibilities. To include the immunisations programme, also integration of the PH function with other council services -such as measures to prevent ill-health and to promote good health, so as to achieve the best overall impact for residents.

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